DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/28/2007 RECEIVED FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA RIMENT OF WHE IND. 0938-0391 AND PLAN OF CORRECTION (X7) MULTIPLE CONSTRUCTION HEALTH REGULATION & SURVEY ADMINISTRATION OMPLETED IDENTIFICATION NUMBER A BUILDING 09G002 B. WING NAME OF PROVIDER OR SUPPLIER <del>2007 H</del>AR 16 1:02/019/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 000 INITIAL COMMENTS W 000 A recertification survey was conducted from February 6, 2007 through February 9, 2007. The survey was initiated using the fundamental survey process. A random sampling of eight clients was selected from a population of twenty-nine (29) clients with various disabilities. On February 8, 2007 at 10:49 AM, the survey was extended in the Condition of Client Protections. The findings were based on observations, interviews with clients, family members, facility staff, school and day program staff, as well as the review of client habilitation and administrative records, including incident reports. The results of the survey revealed the facility was not in compliance with the Condition of Client Protections. 483.410(a)(1) GOVERNING BODY W 104 1. (See W 149) W 104 The governing body must exercise general policy, 2. The agency is clear within its operational budget, and operating direction over the facility. practice who the administration is for each of the programs. Every program has a Program Manager who acts as the administrator for their respective program. This STANDARD is not met as evidenced by: The Program Managers develop and are Based on observation, interview and record responsible for their programs' budget and review, the facility's governing body failed to in the case of the adolescent residential provide general operating direction over the program the funding agencies (MAA, facility as evidenced below: MRDDA) view the residential Program Manager/Residential Program Director 1. [Cross Reference W149] The governing body (RPD) as an administrative position failed to have an effective incident management therefore the RPD is notified and signs policy to ensure client's safety and well being. all of the incident reports and investigations. Historically this has been the practice. 2. The governing body failed to clearly identify The revised policy will reiterate that the the administrator to whom allegations of Program Managers are the administrator for mistreatment, neglect or abuse, as well as 3/21/07 their respective program by 3/21/07. ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Darton (X8) DATE

deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined in a safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(XZ) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE:	0. 0938-039 SURVEY
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NAME OF	PROVIDER OR SUPPLIER				02/0	9/2007
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W 104	Continued From pa	ge 1	101.101	<u> </u>		
	injuries of of unknow	wn origin should be reported sults of investigations should	W 104		·	
	Residential Program the administrator to uneglect and mistreat unknown origin, should be a made of whom the results of its reported. The RPD in the clients living in the	Director (RPD) to determine whom allegations of abuse, ment, as well as injuries of all be reported. Additionally the RPD concerning to nvestigations should be adicated that he reviews and inusual incidents involving e residential facility.		3. The Human Rights Committhe policy on 3/15/07	ttee reviewed	3/15/07
th the second of	confirmed that the RF incident reports and in esidential population, not allegations of abunistreatment are reported in the Chief Executive Oragority of the reports are was no indication erifying that the administrator, administrator.  Cross Reference W verning body failed to the chief	She, however indicated use, neglect and orted to the administrator, fficer (CEO). Although the were signed by the RPD,		I. The concerns outlined in this seleficiencies were reported to the department and this problem was sefore the survey was completed. The Facilities department will enunce equipment check and weather securs in fall prior to winter and prior to summer.	facilities solved 2/9/07. sure that proofing	9/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED B WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 104 Continued From page 2 W 104 Living Unit and the hallways were maintained within a normal comfort range in the residential facility. W 112 483.410(c)(2) CLIENT RECORDS The OMRP removed all posted diet and W 112 retrained staff on meal time protocols. All The facility must keep confidential all information 3/14/07 client personal information is placed in contained in the clients' records, regardless of the their individual program books. form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep confidential all information contained in the clients' record for three of eight clients included in the survey (Client #6, #9, and # The findings include: 1. [Cross refer to W120, 2]. The facility failed to ensure Client #6's therapeutic dietary information 1. The diet order was removed from the was kept confidential. bulletin board at United Cerebral Palsy and placed in a program folder. NCC trained 2. The facility filed to ensure that the dietary staff on confidentiality of medical information of Clients #9 and #10 was kept information on 3/14/07 confidential. 3/14/07 Observation of the bulletin board in the Voyagers 2. The dietary information was removed apartment during breakfast on February 7, 2007 from the bulletin board and placed in their revealed the feeding protocols were posted. program folder. Staff was trained regarding Interview with staff indicated the information is confidentiality on 3/14/07. 3/14/07 posted to provided guidance to all staff caring for

RM CMS-2567(02-99) Previous Versions Obsolete

483.410(c)(4) CLIENT RECORDS

the clients.

W 114

the clients. There was no evidence a system was implemented to ensure that the clients' personal information regarding dietary needs was only available for the individuals assigned to care for

Event ID: 4CB111

Facility ID: 09G002

W 114

If continuation sheet Page 3 of 56

SIMIEWEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) N	III TIELS CONSTRU	OMB (	<u>10. 0938-039</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION		E SURVÉY IPLETED
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NCC				6200 2ND STREET, NW		
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W 114	Continued From pa	age 3	10(4	44		
	Any individual who	makes an entry in a client's it legibly, date it, and sign it.	W 1	14		
	failed to ensure that entries into a clients	s not met as evidenced by: and record review, the facility t each individual making s record signed and dated eight clients (Clients #5 and #) ample.			!	
	The finding includes				·	
	the client had a BSF habilitation records in September 7, 2005. plan revealed it was the licensed psycholostaff on February 8, another copy of a BSF ebruary 6, 2006. A revealed that it too hid attend by a licensed in the client of the control of the control of the control of the client of the cl	residential staff and review of a February 8, 2007 revealed 2. Review of the BSP in his revealed the plan was dated Closer examination of the neither signed nor dated by ogist. Further interview with 2007 revealed that there was SP for Client #5 dated dditional review of this plan ad neither been signed nor psychologist. At the time of y failed to ensure Client #5's d.		1. A signed and dated copy plan was placed in his habilion 2/10/07, unsigned or und will be clearly marked as dr	itation records lated assessments	2/10/07
a fo w p a ha V 120 48	pproximately 10:20, pproximately 10:20, pring that was not significated Mei the Qualified Mei rofessional on February 11:25 A ad not signed on date	Lary 9, 2007 at  AM acknowledged that she led the client's rights form.  CES PROVIDED WITH	W 120	2. A signed copy of the client's was placed in her program fold. This individual does not have at this time. A petition for a mewas filed in June 2006.	ler 3/14/07.	3/14/07

PRINTED: 02/28/2007 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF DEFICIENCIES	CVI) PROVERS	<del></del>		FURI	M APPROVE
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NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			02/	09/2007
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W 120	1 sommer i form par	ne 4	100			
	The facility must ass meet the needs of e	Sure that outside :	W 1.	20		
I F C F P III N M as kr	failed to ensure that sample (Client #1, #2 were provided outsid with their needs.  The findings include:  1. The day program for offered the opportunite eating utensils during.  During observation of program on February provided with a plastic eatorie low cholesterol program instructor indureferred to use the platerview revealed that ever been provided for eattimes. There was seessed to determine hife during mealtime.  The day program fail	the lunch meal at the day 07, 2007, Client #7 was spoon to eat her 1600 diet. Interview with the day icated that the client astic spoon. Further forks and knives had or the client to use at no evidence the client was her ability to use a fork or		1. QMRP has met with school prog 3/6/07 to address giving choices ar appropriate eating utensils. Client be offered all utensils during mealt OT assessment of client #7 abilities scheduled for.	d using #7 will	3/6/07
OI Fe bo bo ind vis	bservations conducted bruary 7, 2007 at 11: ard on the class room ard was Client #6 's in licated that she was ditor entering the class	d at the Day Program on 02 AM revealed a bulletin wall. Posted on the personal information that		The QMRP met with the day progra 3/13/07. See W 112. QMRP Assessed client # 6's ability to wipe her mouth asked. Client # 6 demonstrated the a to wipe her mouth w/ verbal and gescues.	ed n when bility	
CMS-2567/02					.	- 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

	AND PL	AN OF CORRECTION	IDENTIFICATION NUMBER:	l l		IPLE CONSTRUCTION		C. 0938-0: SURVEY	<u>39</u>
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	N C C	DF PROVIDER OR SUPPLIER			٥	REET ADDRESS, CITY, STATE, ZIP CODE 200 2ND STREET, NW	02	/09/2007	_
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	W 12	a sinting of thom pay	ge 5	100	20				
		the Qualified Mental QMRP) on the same PM acknowledged the should not have been as to address to address observation at Client 7, 2007 at 11:06 AM, treatment area seate a wall. The client was bib that was stained a female staff member mouth. The client thereafter, a male stawipe her mouth and the touching her left hand her mouth with the started.	Retardation Professional (ed day at approximately 2:30 hat Client #6 's information in posted on the bulletin boast failed to implement effectives Client #6's drooling. It #6 's day program Februar revealed the client in her don a chair located against sobserved wearing a white At approximately 11:13 AN er asked Client #6 to wipe idid not respond. Shortly ff member asked her to hen prompted her by and directing her to wipe lained bib.	ard e ary		A meeting was held on 3/13/07 w program to address client #6's abi her mouth. NCC will informally n client #6 ability to wipe her mouth	lity to wine		
	V 122	:02 AM revealed that the place to assist Client the using the appropriate in paper towels). Interview residential facility revealer mouth independent support staff offer Client towel to wipe her mouth.  4. [Cross refer to W362 ensure drug regimen residential facility reveals to the paper towel to wipe her mouth.]	ew with the QMRP at the aled that Client #6 wipes tly. At no time did the nf #6 a napkin and/or paper h.  2]. The pharmacy failed to eviews were conducted at ts #1, #2, #3, #4, #5, #6, #  TECTIONS			4. The pharmacy had completed a pharmacy review on November 20. The pharmacy changed their tracking occess.	2006.	2/12/07	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/28/2007 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G002 B. WING NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION . REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG PREFIX (X5) COMPLETION REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 122 Continued From page 6 W 122 This CONDITION is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure each clients clothing was the appropriate size (See W137); failed to establish and/or implement policies that ensure the maintenance of each client's health and safety (See W149), failed to notify the designated administrator and other officials were immediately informed of allegations of abuse ( See W153), failed to thoroughly investigate incidents of abuse (See W154); and failed to report the results of the investigation within five working days (See W156). The effects of these systemic practices results in the failure of the facility to protect its clients and to ensure their general safety and well being 483.420(a)(3) PROTECTION OF CLIENTS W 125 W 125 **RIGHTS** HRC committee has reviewed policy for The facility must ensure the rights of all clients. lock door policy for each individual Therefore, the facility must allow and encourage 3/15/07 affected. individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client was encouraged to exercise their rights, for eight of the eight clients (Clients #1, #2, #3, #4, #5, #6, #7 and #8) included in the sample. The findings include:

STATEM	ENT OF DEFICIENCIES	T. WEDICAID SERVICES	<del>,</del> -		OMPINO	0.0938-039
AND PLA	NO OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A BUIL	JLTIPLE CONSTRUCTION DING	(X3) DAYE S	SURVEY
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NAME C	PEROVIDER OR SUPPLIER	09G002			02/0	09/2007
NCC	- WOVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD 6200 2ND STREET, NW	E OZIO	3312001
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W 12	Continued From page	ge 7	10/ 15			
	1. The facility failed	to ensure the clients had free	W 12	25		
W 137	Observations condurevealed the facility could neither enter of Further observation none of the clients in facility. Interview with February 8, 2007 reviocked because their facility that were known the Program Manageremained locked as a unwanted people from Interview with the Diron February 9, 2007 to the residential facility during business hour survey the doors were	cted throughout the survey was locked and individual or exit the facility without a key in and interview revealed that in the sample had a key to the high the Program Manager on realed the facility remained as were clients living in the winto abscond. Additionally, ar revealed the doors a means of safety to keep in entering the facility revealed that the front doors ity usually remained open is however, at during the	W 137	3/15/07 Some new clothing will be	ed on	3/15/07
	The facility must ensu Therefore, the facility have the right to retain personal possessions	must ensure that clients and use appropriate and clothing.		purchased within the next 7 days. fitting clothing will be removed by and client #4 will be receiving some clothing within the next 7 days.	All non-	3/21/07
	This STANDARD is n Based on observation failed to ensure each of appropriate size, for or Client # 4) included in	ne of the eight clients (	·			
	The finding includes:					1
	Observation at Client # February 7, 2007 at 11	4's day program on :56 AM revealed the client				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/28/2007 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB\_NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PŘÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG COMPLETION DATE W 137 Continued From page 8 W 137 seated in the music room. The client was wearing black faded jeans with a belt, a green turtleneck, and black shoes. At 12:03 PM, the client was asked to go to the restroom to wash his hands prior to lunch. The client stood up and his pants were observed below his waist and his green underwear was exposed in the back. As the client walked to the restroom, the client was observed to hold onto the waist of his pants. Additional observation of the client's pants revealed the pant legs of the pants were long and very large. Interview with the Residential Counselor on February 6, 2007 revealed that he verbally prompts Client #4 to pull up his pants several times throughout his shift. Interview with the Qualified Mental Retardation Professional (QMRP ) on February 9, 2007 revealed that she shops for all of Client #4's clothing, however has some difficulty in selecting clothing for men. The QMRP further indicated that Client #4 is non-verbal and See W137 for additional information is not able to choose his own clothing. At the time of the survey, the facility failed to ensure Client #4's pants were well fitting and appropriately sized. 483.420(d)(1) STAFF TREATMENT OF W 149 W 149 CLIENTS 1. The Supervisors and Program Director will I The facility must develop and implement written ensure that the incident reports completed 3/15/07 policies and procedures that prohibit and signed in accordance with agency policy. mistreatment, neglect or abuse of the client. This is effective immediately as of 3/15/07

VM CMS-2567(02-99) Previous Versions Obsolete

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety of eight of the eight clients (Clients #1, #2, #3, #4, #5, #6, #7, and #8)

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Facility ID: 09G002

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with the Director of Quality Improvement on

February 8, 2007, revealed the Residential

administrator who reviews unusual incidents

Program Director was designated as the

involving the residential population. She,

timely manner,

such a manner.

This will be evidenced by 3/12/07

There is no regulation that specifies that the

CEO must be the administrator who reviews

the incidents nor has the agency historically

operationalize the function of the CEO in

3/12/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED B. WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X5) COMPLETIO≥! DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) W 149 Continued From page 10 W 149 however indicated that allegations of abuse, The incidents of unknown origin are neglect and mistreatment are reported to the always investigated. The forms used administrator, the Chief Executive Officer (CEO). for notes during an investigation of Although the majority of the reports were signed an injury of unknown origin has been by the RPD, there was no indication or revised and should help outline the documented evidence verifying that the measure used to determine the possible administrator (CEO) had reviewed/signed all origin of a clients injury (see attachment) incidents/investigations, or that the CEO had designated the RPD to act as the administrator. This was completed on 2/7/07. At the time of the survey, the facility failed to develop and/or implement an incident management policy that was in compliance with the federal regulations. 2. The facility failed to implement and provide evidence of a reproducible system to investigate injuries of unknown origin. Review of unusual incident reports on February 6, 2007 beginning at 11:19 AM revealed there were 12 injuries of unknown source from July 6, 2006 through July 31, 2006. Further review of the incident reports revealed a possible origin of the injuries was documented on the face of the reports. The incident reports however did not indicate what measures were used to determine the possible origin of the clients' injuries. gin 2/7/07 According to the "Incident Management Policy" 'n in the section entitled "Injuries of Unknown Origin ", the policy presented steps to be taken by the facility to ascertain information regarding how an

injury occurred. The policy documented, "For injuries of unknown origin that are minor in nature, i.e. require minor first aid and are suspicious based on the nature or circumstances of the injury, the functional and medical status of the individual, or the environment in which the individual has been placed a modified

l	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(22) 1444	Tiple	OMB N	<u>O. 0938</u> -039
	AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER	A BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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	NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW WASHINGTON, DC 20011	02/	09/2007
	(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE		(XS) COMPLETION DATE
	a a a a th p re a at th Ei 20 Fe ch 20	format had been imported timely review of the by the HRC for Client Interview and record at 10:37 AM revealed revealed a Review of Procedure Use form physical and chemical the policy on Februar Human Rights Common Rights Common Rights Common Rights Common Rights Common Rights related issues of restrictive techniques of the policy of the shall meet once a monall rights related issues of restrictive techniques of the policy of the pol	is used". rvey, the facility failed to at the modified investigation olemented.  to implement its policy on the Emergency Use of Restraints ts #1 and #2.  review on February 8, 2007 if the incident manager Emergency Restrictive is completed after each at restraint. The review of y 9, 2007 revealed that the nittee (HRC) chairperson incident by next business agency's policy, the HRC onth to review and evaluate is, including the emergency niques.  dated May 3, 2006 revealed was placed in a one person int and also received g IM as emergency due to his physical to respond to repeated interview with the QMRP rebruary 9, 2007 indicated completed the Review of Procedure Use on May 16 the HRC Minutes/ed the Emergency Use of tion (Physical and not reviewed until July 24,	W 149	· <del>  </del>	gency's ocal y will e nts act	3/31/07
((	CMS-2567(0)	2-99) Previous Versions Oben		<del></del>	<del></del>		- 1

DE	PARTMENT OF HEALTI	H AND HUMAN SERVICES					
_CE	NTERS FOR MEDICARI	& MEDICAID SERVICES				PRINTE	D: 02/28/2007
101711	*MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	<del> </del>			OMB NO	M APPROVED 2. 0938-0391
ANDP	LAN OF CORRECTION	IDENTIFICATION NUMBER			IPLE CONSTRUCTION	(X3) DATE	2. 0936-0391
1			A BU	ILDIV	4G	COMP	LETED
	<del>_</del>	09G002	6 WI	NG			
NAME	OF PROVIDER OR SUPPLIER			<del>, `</del>		02/	09/2007
NC				STE	REET ADDRESS, CITY, STATE, ZIP CODE	- 02/	03/2007
""	·			ı۷	ZOO ZNU STREET, NW		
(X4)	ID SUMMARY STA	TEMENT OF DEFICIENCIES	<del>, _</del>		VASHINGTON, DC 20011		
PRE	''^   \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	MUST BE DOCCOOD by a	ID		PROVIDER'S PLAN OF CORRECTIVE ACCUSED		<del>,</del>
TΑ	REGULATORY OR L	SC IDENTIFYING INFORMATION)	- PREF		(EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPENDIX	JN E CROSS-	(X5) COMPLETION
10/					REFERENCED TO THE APPROPRIATE DE	FICIENCY)	DATE
W 1	y shanaca i totti pag	ge 12	W 1	40		<del></del>	<u> </u>
	revealed at 8:06 AM	, Client #2 was placed in a "	"	49			
	Tone man restraint	due to holfing from her					1
	Classicom and runn	ing the hallway of the cohe-t					1 1
	Turio trie stairwells. A	CCOrding to the report 45 -					<b>!</b>
	when they afternoted	ical aggression toward staff I to get her to return to the					1
	CIGGGGTOVIII, THE FEVI	ew of the HRC Minutes (					
	Leeopack Form reve	aled the Emergency Upa as					
	Livear durining Rest	FICTION (Physical and					ı
	unemical restraint) w	29 not reviewed until A				ĺ	1
	This Apply There was	no evidence the thirty				1	- 1
	Augmenting UKC MS	S notitied of the amore - "				- 1	1
	by agency policy.	business day as specified				1	j
	1			İ			
	4. The facility failed to	o have a system for the			4. The incident reports have a section the form that indicates - 1	_	- 1
	I """"Cuiate Hollication	) Of the administrate					ĺ
	Time May May COUGHE	ted with the Desident 1	1				İ
	Triogram Director (Kh	1)) on February 6, 2007		1			3/15/07
	reviews unusual incide	designated person who					1
	reviews unusual incide indicated that he signs	the unusual is at the					ļ
	reports. The review of	f the unusual incident			(by history and practice) who has alwa reviewed the incidents.	VS	}
	Treports (evealed they d	Should have a size - 1		'	reviewed the incidents.	- 1	i
	T Administra & Michalle	Litector/Monogen Day				Ϊ	j
	to dottermine the status	(open or closed) of the					l
	incident.	,					1
	The review of twoter:			1			
	the incidents had been	cidents revealed three of			·		{
	WUINING GAVS (Seven) a	ffor the incident To the			W	.]	
•	Landing including IBAIBA	CO DO evidence tha			#5 Nursisng Staff were instructed	1	- 1
	administrator had been	notified.			m Dack to Basics Pharmacy"	1	3/8/07
					inservice 3/8/07 and have reviewed	1	.
	5. The facility failed to in	mplement their policy on		1	the current medication policy periodic		1.
	Disposal of Drugs as ev	idenced by:		í	nursing meetings will continue as teaching opportunities to review	.	
1	Observation of the access	:	J	Į	policies/ best practice principles.		1
	Observation of the even February 6, 2007 reveal	ing medication pass on	1	(	See Attachment#1 and #2)		
		en mar rue Ficeused			- make IFZ)		1

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES  MEDICAID SERVICES			PRINTED	): 02/28/2007 1 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING	OMB NO	). 0938-039 <sup>.</sup> Survey
<u> </u>		09G002	B. WING			
N C C (X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	TREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECT		9/2007
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	h	(X5) COMPLETION DATE
	Practical Nurse (LP milliliters of Colace observation reveale approximately 2 mill a regular plastic line the LPN revealed the administered only 10 and that she had to medication. Review Drugs revealed that by the nurse administered that the medication with facility's policy.  6. [Cross Refer to Wimplement its policy or required that the nurse health/medical conditions are Physician (PCP 483.420(d)(2) STAFF CLIENTS  The facility must ensure injuries of unknown simmediately to the adofficials in accordance established procedure.  This STANDARD is reasoned to ensure all alkabuse, and injuries of allegations of the stables of the s	N) prepared approximately 12 liquid for Client #9. Further d that the LPN poured illiters of the Colace liquid into d trash can. Interview with at Client #9 was to be in milliliters of Colace liquid discard the excess of the policy on Disposal of wasted drugs shall be made stering the medication in the wag. There was no evidenced was discarded according to wasted "Weights" that se to evaluate the clients' tion and notify the Primary of the findings. TREATMENT OF the findings of the orabuse, as well as ource, are reported ministrator or to other e with State law through es.	W 14	The current weights procedure has be reviewed. Pertinent information will incorporated into a new policy entitl "Nursing Documentation in the med record. This will be issued on or bef 4/15/07 at which time the weights procedure will be discontinued.	l be led lical ore	4/15/07
! 7	The finding includes:		. ]			1.

STATE	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(VE) M		OMB NO	). 0938-039
AND P	LAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY
	<u> </u>	09G002	B WING	·		
NAME	OF PROVIDER OR SUPPLIER	<u> </u>	<del>-   -  </del>		02/0	09/2007
NC	С	•		TREET ADDRESS, CITY, STATE, ZIP C 6200 2ND STREET, NW	ODE	
(X4)	ID SUMMARY STA	TEMENT OF DEFICIENCIES	<del>,</del> _	WASHINGTON, DC 20011		
PRÉ TA	FIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	1010	(X5) COMPLETION DATE
W 1	Continued From pa	ge 14	W 15	3		
	Review of unusual in 2007 beginning at 1 12 injuries of unknown client biting another client pushing another client pushing another under that there were areas supervisor and Program procedure is to sign them.  Review of the facility' Policy' on February 6 are categorized into sign transcriptions and program procedure is to sign them.	Manager indicated the usual hese forms after reviewing s "Incident Management , 2007 revealed incidents serious reportable and The policy stipulated that le and reportable incidents rogram Director. It		1. The agency will ensure that is followed. In addition the incare reviewed and signed by the Director/Manager. The Incide policy will be reviewed (modinecessary) to ensure it compliand local regulations this will by 3/21/07	cident reports e Program nt Management fied if deemed es with federal	3/21/07
	within one workday of	ne Incident Report form receipt of the form."				
	administrator was the however the Residenti designated to conduct the incidents. At the tir failed to provide evider	with the Director of Quality Lary 8, 2007, revealed the Chief Executive Officer, al Program Director was the initial review and sign ne of the survey, the facility noe that the administrator ad been made aware of the nts				
M CMS-2	567(02-99) Previous Versions Obser			<del></del>		1

PRINTED: 02/28/2007 FORM APPROVED OMB NO. 0938-0301

	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(۷2)	41 (1 T	101 F 0 - 114 - 1	<u> TOMB NO</u>	<u>). 0938-03</u>	<u>9</u> 1
	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. 8U		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED		
ı			09G002	B WII	NG _				
I	NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	02/	09/2007	
I	NCC		•	•	6	200 2ND STREET, NW			
ŀ	(X4) ID	SLIMMARY STA	TEMENT OF OFFICIENCE	<del>, -</del>		VASHINGTON, DC 20011			
	PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCÉDED BY FULL SC (DENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	DC 00000	(X5) COMPLETIO DATE	ж
	W 153	Continued From page	ge 15	W	153			<del></del>	
		2. The facility failed mistreatment negled the administrator in example:  The review of an univolvember 7, 2006 mone of his classmate oral sex and taking hereord review on Fel investigation was con 2006 and reviewed by manager on November 1, 1, 2, 2, 2, 3, 3, 4, 4, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5,	to ensure each allegation of ct or abuse was reported to accordance with state law for usual incident report dated evealed Client #11 alleged as was making him perform his money. Interview and bruary 8, 2007 revealed the impleted on November 15, by the designated program per 20, 2006. There was no strator was notified of the		,	2. The Program Manager (Administration the program where the incident was notified on: when the Program Manager was notified, in effect the Administrator was notified.	reident occurred		
		log book on February approximately 11:00 injuries were not repo Health (DOH) as evic a. On 1/27/07, Client	AM revealed that following orted to the Department of			3. (a-e) The program will coordinate the Quality Improvement Department ensure that the agency is compliant all the reporting requirements mand federal and local regulations this will effective as of 3/16/07.	nt to with	3/16/07	·
	10	o. On 9/3/06, during Client #11 bit Client # nim.	an episode of agitation., 1 who was sitting beside			**************************************			
	o n	: On 1/29/07, Client nark the size of a ten	#12 was found with a red nis ball on his body.			·			
	l h	ematoma (lump mea	#13 was discovered with a suring about 1½ inches while receiving medications						
	e	On 9/10/06, Client:	#14 was discovered with						
1	M CMS-2567/	(02-99) Provious Ventene Ob-	-1-4-	<del></del>	<del></del>				ı

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	HAND HUMAN SERVICES  E & MEDICAID SERVICES			PRINTEC FORM	): 02/28/200 1 APPROVE
STATEMEN	T OF DEFICIENCIES		<del>- ,</del>		OMB NO	<u>0</u> 938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		09G002	B WING			
NAME OF F	PROVIDER OR SUPPLIER				02/0	9/2007
NCC			5	TREET ADDRESS, CITY, STATE, ZIP CC 6200 2ND STREET, NW	DDE	
	<b>-</b>			WASHINGTON, DC 20011		
(X4) ID PREFIX TAG-	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION SHI REFERENCED TO THE APPROPRI	21 / D DC 000	(X5) COMPLETION DATE
W 153	Continued From pa	ge 16	W 153			<del> </del>
		left eye during a body check.	VV 13.	?	,	
W 154	483.420(d)(3) STAF CLIENTS	FF TREATMENT OF	W 154	1		
	The facility must ha violations are thorou	ve evidence that all alleged ughly investigated.				
	Based on interview :	s not met as evidenced by: and record review, the facility gations of abuse were ted.			'	
	The finding includes	<u>.</u>			1	
	February 6, 2007 be an incident dated Se Client #2. According client alleged having male client. Addition her "butt" hurting and pink/brown substance when the client wiped nursing progress not 2006 at 4:30 PM revenurse to observe pinkshe had used. The clean ination by the substance of the LPN examination of the cliex udate or frank blee to the progress note, aurt but she was "ok" emergency room for fronsensual sexual achicident investigation	upervisory RN in the During the visual ent's rectal area, no fissure, ding was noted. According the client stated her "butt" The client was sent to the follow-up on the alleged non- tivity with another client. The		Client #2 was seen at GYN cli Washington Hospital Center of The need for further examinat ruled out by treating physician (See attachment for additional	on 10/24/06. ion was	3/16/07

to be evaluated at the ER. Although the results of

CEN	TERS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	D: 02/28/2007 A APPROVED
STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		096002	B WIN	<del></del>	COMPL	E.ED
NAME	OF PROVIDER OR SUPPLIER	030002	<del>;</del>		02/0	9/2007
NCC	<u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW WASHINGTON, DC 20011		
(X4) I PREF TAG	A LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORP.		(X5) COMPLETION DATE
W 1	the investigation cou	ald not substantiate sexual iled to address the origin of	W 15	See responses to W 149 and W	153	
W 156	Incident reports on F 11:19 AM revealed to unknown source, 2 control and 1 pushing another client, and 1 pushing another client, and 1 pushing another client, and 1 pushing another client, and 1 pushing another client, and 1 pushing another client, and 1 pushing another client, and 1 pushing another client, and 1 pushing on the face of possible nature of the information however, investigation was continterviewed, and how based on the investigation was continterviewed, and how based on the finding strate of investigated. (See alse 483.420(d)(4) STAFF CLIENTS  The results of all investo the administrator or or to other officials in a within five working day.  This STANDARD is no Based on interview and failed to ensure that into the administrator or with in five working day.  The findings include:	a conclusion was made ation. At the time of the ed to provide evidence that icidents were thoroughly so W149) TREATMENT OF  stigations must be reported designated representative accordance with State law is of the incident.  of met as evidenced by: directly restigations were reported designated representative is of the incident, for		See responses to W 149 and W 15	3	
	The facility failed to hav	e a system for the timely				

STATEM	ENT OF DEFICIENCIES  N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MID VIOLE A CO.		OMB NO	OMB NO. 0938-039	
	W OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE COMPL	SURVEY	
		09G002	B. WING	G			
NAME O	F PROVIDER OR SUPPLIER		<del></del>		02/	09/2007	
NCC	NCC		;	STREET ADDRESS, CITY, STATE, 2 6200 2ND STREET, NW	ZIP CODE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<del>,</del>	WASHINGTON, DC 20011			
PREFIX TAG	V CACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTIO REFERENCED TO THE APPR		(X5) COMPLETION DATE	
W 15	W 156 Continued From page 18						
	notification of the a	dministrator	W 15	i6			
	a. [Cross Refer to conducted with the RPD) on February (designated person incident reports and the unusual incident have a signature comanager Review to closed) of the incident. The review of three revealed they had be administrator more that the incident. For psychological was must be investigation with the revealed they had be administrator more that the incident.	W153] Interview was Residential Program Director ( 5, 2007 indicated he was the to review and sign unusual I investigations. The review of t reports revealed they should infirming a Program Director/ determine the status (open or ent.  see of twelve incidents seen reviewed by the han 5 working days (seven) or example, an allegation of lade on September 112, 2006 as completed on September by the Residential Programs					
t t	had been notified of to investigation. For example, allegation of Sexual A September 19, 2006, of Quality Improveme confirmed that the RP incident reports and investigations of abundant allegations of abundant residential population, that allegations of abundant reatment are reported the Chief Executive Of this investigation failed allegations of sexual and the time of the survey, of provide evidence the	ample, Client #2 made an Abuse and Staff Neglect on Interview with the Director of (QI) on February 8, 2007 D signs the unusual exestigations for the She, however indicated ese, neglect and extend to the administrator, officer (CEO). The results of the substantiate the buse and staff neglect. At however the facility foiled					

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I	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1,,,-		<u> ОМВ N</u>	<u>O. 093</u> 8-03	391
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		IULTIPLE CONSTRUCTION LDING	(X3) DATE		
I			09G002	a wiv	NG			
1	NAME OF F	PROVIDER OR SUPPLIER		<del></del>	CTREET ADDRESS	02	/09/2007	_
	NCC				STREET ADDRESS, CITY, STATE 6200 2ND STREET, NW WASHINGTON, DC 2001			
Į	(X4) 1D	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID				
	PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG	A   CACH CORRECTIVE ACT	NOF CORRECTION FION SHOULD BE CROSS- PROPRIATE DEFICIENCY	(X5) COMPLETIC DATE	)N
l	W 156	Continued From pag	ne 19	W 1	56		<del></del>	
	10/ 455	or designated repres days of the incidents	sentative within five working	VVI	50		,	
	W 159	483.430(a) QUALIFI RETARDATION PR	ED MENTAL OFESSIONAL	W 1	59.			
		Integrated, coordinat	reatment program must be ied and monitored by a					
		qualified mental reta	rdation professional.		See W137 pg	<b>3</b> 8		
	ŀ	Based on observation review the facility fail	not met as evidenced by:  n, interview and record  ed that each client's active  ras coordinated, integrated  e Qualified Mental  pnal (QMRP)			.		
		The findings include:				:		
		<ol> <li>The QMRP failed treevived the appropriacocordance with his recordance</li> </ol>	o ensure that Client #4 ate clothing size in needs. [See W137]		1. See responses to W 13	37 Pg 8		
	1.1	2. The QMRP failed training on Client #4's 189]	to ensure that staff receive feeding protocol. [See W					
	/ €	I.[Cross refer to W19 ensure direct care sta Behavioral Support Pl	3]. The QMRP failed to ff implemented Client #7's an (BSP).	÷	2. QMRP will add adaptithat address eating w/ ute Staff will also be trained of this goal.		3/20/07	
	to a	ransition plan that doc and necessary suppor to her transition to a le	o ensure Client #2 had a cumented areas of concern ts needed by the client prior ast restrictive environment.		of this goal.  4. Staff will be retrained of	1		
	6	See W202) The QMRP failed to	ensure each client's		BSP by 3/20/07	in Chent # /'s	3/20/07	
	M CMC DECT	<del></del>	nal assessment identified					

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION		OMB NO. 0938-039	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A BUIL		(X3) DATE COMPI		
<u></u>		<b>09</b> G002	B WIN	G		•	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	-	STREET ADDRESS CITY OF THE	02/	09/2007	
NCC			ļ	STREET ADDRESS, CITY, STATE, ZIP C 6200 2ND STREET, NW	ODE		
			Ì	WASHINGTON, DC 20011			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CO	ORRECTION	<del></del>	
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFY:NG INFORMATION)	PREFI) TAG	(EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROPR	HOULD BE CROSS	(X5) COMPLETIO DATE -	N
W 159	Continued From pa	ge 20	W 1	59			
	specific the specific	limitations that justified the	'''	5. QMRP will write a transit	tional -la-		
	client's food being k	ocked. (See W214)		for client #2 by 3/16/07	y 3/16/07		,
	7 The OMRP failed	d to ensure Client #5's		6. The facility could not iden	itify a client to		
	Behavior Support P	lan (BSP) had been updated.		THE CHAIN THE CA	Alea A. Y		
				outpervisor on 3/15/0/ and ad	lvised to omit.		
	record on Eabruan	and review of Client #5's		7. See response to W 114 #1	l		
	record on February 8, 2007 revealed the client had a residential BSP. Review of the BSP that						
	was maintained in h	is habilitation records		l a cru i	•		l
	revealed the plan was dated September 7, 2005 Closer examination of the plan revealed it was		ĺ	8. Clinical team met with NC	C Dietician	3/13/07	
	neither signed nor d	of the plan revealed it was		on 3/13/07 and she ensured the clients will receive appropriately	ie team that		
	psychologist. Furthe	er interview with staff on		The volvare, Condiments will be	sa mada		1
	February 8, 2007 rev	realed that there was another		available to clients at meal tin	nes.		
	↓ copy of a BSP for CI	ient #5 dated February 6					
	it too had neither be	riew of this plan revealed that en signed nor dated by a					
	licensed psychologis	t. At the time of the survey		9. QMRP will make addendu	ms to client	3/21/07	1
	I the QMRP failed to a	ensure Client #5 had a		The water of long An adapted.	T 'TT	3/41/0/	1
	current copy of his B	SP.		will be implemented on 3/21/0 be trained on this goal by 3/21	D7 C4 CC		
	8. The QMRP failer	I to ensure clients were					1
	provided with opporte	unities for choice and self-		Client # 2's eye exam on 3/14 tha she did not require	/07		
	management. (See	W247)		tha she did not require eyeglas attachment)	ses (see	3/14/07	
	9. The QMRP failed	to ensure that Clients #1, #2					
	and #4 was taught to	use and make informed		Clients # 5, 9, and 10; wheelch	lairs were		ı
	choices about his eye	glasses and failed to closely		serviced on:			
	, #9, and #10. [See \	of wheelchairs for Clients #5		Client #5 on 3/31/07 Client #9 on 3/2/07			١
	, o, and (oee )	1400]		Client # 10 on 3/9/07		•	
	10. The QMRP failed	to coordinate timely with the		(see attachment for receipts) ch	iairs		l
VA/ 400	nutritionist regarding	Client #7's weight loss		continue to be monitored by nu	rsing staff.		
W 189	403.430(e)(1) STAFF	TRAINING PROGRAM	W 189				
]	The facility must prov	ide each employee with		10 IDT meeting was 1-11	. 1	ı	l
]	initial and continuing t	raining that enables the		10. IDT meeting was held to d client #7 weight loss with Nutr	iscuss	2/9/07	l
	employee to perform	his or her duties effectively,		on 2/8/07. (see attachment for	mtg notes)	2/8/07	
PM CMS 250	67(02-99) Pravious Varriose Ob						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED 8 WING 09G002 02/09/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG. REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLÉTION-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 189 Continued From page 21 W 189 efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide each employee with initial and continuing training that enables the employee to perform his or her duties, effectively, efficiently, and competently for two of eight clients included in the sample. ( Clients #1 and #4) The finding includes: 1. Observations of the dinner meal conducted on February 6, 2007 at 5:39 PM revealed Client #4 1. Staff will be trained on client's meal eating Spanish rice and string beans from a protocol by: Styrofoam plate with his hands while the 3/20/07 Residential Counselor beside him. Further observations revealed Client #4 eating a fruit cup with his hands as well. Interview with the Residential Counselor on the same day at approximately 5:47 PM revealed that Client #4 feeds himself independently. Interview with the Qualified Mental Retardation Professional (QMRP) on February 9, 2007 revealed that staff had not been trained on Client #4's feeding protocol. There was no evidence staff attempted to redirect the client to use his eating utensils.

Policy "

2. [Cross Refer to W149]. The facility failed to

trained on the facility's "Incident Management

3. [Cross Refer to W193, 2]. The facility failed to

provide evidence that staff were effectively

policy

2. Staff will receive training on Incident

3. Staff will receive training on wellness

management protocol by:

Also see response to W 159 #2

4/15/07

4/15/07

PRINTED: 02/28/2007 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE S	
l			A BUI	LDING	<del></del> _	COMPL	.ETED
		09G002	B WIN	1G		03/00/000 <del>-</del>	
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	02/0	09/2007
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<del></del>		ASHINGTON, DC 20011		
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W 189	Continued From pa	ge 22	W 1	89		<del> </del>	
	ensure staff was effectively trained on the implementation of Client #1's therapeutic diet.  According to a written statement by the QMRP dated November 20, 2006, a staff escorted the client to the vending machine and the client purchased sweets. The food was later taken from the client by other staff after the client			1800 calorie diet by 3/20/07. It staff will be trained on NCC's		10.0	3/20/07
					policy annually.		
					•		
	returned to the resid	ntial facility. The client was good for him and staff would					
	ask the dietitian if th	e client could have some of					
	the food he purchas	ed, since the client is on a ent became upset became					
	the food was taken :	away and became aggressive	;				
	. Interview with the r 2007 indicated the s	nutritionist on February 7, taff did not require much					
	training on the thera for the clients require	peutic diets because the food					
	preportioned on plate	es in the kitchen before					
	bringing it to the dini evidence the staff wa	ng room. There was no as effectively trained on foods					·
	allowed on the client	's therapeutic diet (1800					]-
W 193	calorie, low choleste 483.430(e)(3) STAFI	roi). F TRAINING PROGRAM	W 19	3			
l		demonstrate the skills and	'' '		•		ľ
	techniques necessar	y to administer interventions				$\square$	
	to manage the inapp	ropriate behavior of clients.					
	This CTANDADD :-						
	Based on observation	not met as evidenced by: ns, staff interviews and the					
j	review of records, the demonstrate compete	e facility staff failed to ency in the implementation				Ī	j
- 1	of the Behavior Supp	ort Plans (BSP) for two of				1	
	eignt clients in the sa	mple. (Client #1 and #7)					
-	The findings include:						
		·					1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 193 Continued From page 23 1. Observation on February 07, 2007, at 1. Staff will be retrained on program. approximately 3:17 PM revealed that the Qualified QMRP will continue to monitor and coach Mental Retardation Professional (QMRP) verbally prompted and signed to Client #7 to point to what staff to engage clients and implement she wanted from several picture symbol cards. behavior management programs. 3/20/07 Client #7 was observed to point to a picture of a Also see response to W 159 #4 food item. The client than got up from her chair and walked over to a table and picked up a small four ounce container of orange juice. Staff took the orange juice container from the client, stating that she was allergic to orange juice. Client #7, returned to her chair and head butted another client that was sitting on a sofa next to her chair. The client that was assaulted and several other clients in the vicinity were removed from the area. Further observation revealed that the staff did not attempt to engage the client in any further activities. Interview with the staff revealed that they had been trained on the Client #7 's Behavior Support Plan (BSP). Review of the BSP dated October 13, 2005( expiration date January, 2008) revealed that the client has targeted behaviors that included physical aggression( head butting, hitting, kicking), self-injurious behavior, oppositional behavior, hyperactivity, short attention span, poor concentration, distractibility, low frustration tolerance, poor impulse control, fecal smearing, and temper tantrums. Further review revealed that if the client becomes physically aggressive towards others she should be directed to complete program activities after any behavior in order to avoid inappropriate reinforcement of target behavior. There was no evidence that staff demonstrated competency in the implementation of Client #7 's BSP. 2. The facility failed to ensure staff were effectively trained on the management of Client #

1's Maladaptive behaviors.

W 193  Continued From page 24  Interview with staff on February 6, 2007 revealed that Client #1 has a behavior support plan which includes interventions for aggression (verbal and physical), bolting, and non-compliance. According to the agency's investigation of a serious reportable incident, Client #1 exhibited physically aggressive behavior on November 20, 2006 at 6: 00 PM which resulted in several Mandt Restraints over a period of approximately 45 minutes and a telephone call for emergency assistance (911). The police arrived and place handcuffs on the client when he became aggressive toward them. The client was then taken from the ICFMR to a hospital where he remained for treatment. He was readmitted to the facility on November 27, 2006 in stable condition.	0000 ***
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hospital where he remained for treatment. He was readmitted to the facility on November 27, 2006 in stable condition.	
was readmitted to the facility on November 27, 2006 in stable condition.	•
2006 in stable condition.	
2000 III Stable Condition.	
Record verification on February 9, 2007 revealed	l
Offer #1 flad a penavior support plan which	- 1
addresses politing, noncompliance verbal	l
aggression, aggressive hehavior regressive	ļ
behavior and inappropriate sexual behavior. The	i
functional analysis indicated that when unit staff fall to notice and identify the warning signs of his	
irritability or anger, his irritability can quickly	
escalate to aggression and bolting. Further the	
Client's limited coping skills and being upset when	1
The is angry, which may often lead him to engage	1
in physical aggression against staff and poor	
property destruction and or/or bolting. The BSP	1
includes a proactive strategy which states "When staff notices that [Client #1] is upset or agitated	
about something, after two afternots to help him	1
dear with what is upsetting him, staff should	
always give [Client #1] a break from the situation	- 1
Stati should retrain from continuing to talk to t	1
Client #1] about the situation when he is	
noticeably upset and allow him to calm down in	

CEIN	ERS FOR MEDICARI	= & MEDICAID SERVICES			OMO NO	APPROVE
AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL1	TIPLE CONSTRUCTION	(X3) DATE S	0. 0938-0391
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NAME O	F PROVIDER OR SUPPLIER	<u> </u>	107		02/0	9/2007
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ļ				WASHINGTON, DC 20011		
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<u> </u>				REFERENCED TO THE APPROPRIATE	DEFICIENCY)	DATE
W 19	a a minimum troin pa		W 193			<del></del>
	his room or away fr	om the group. Staff should				
	Client #11 is visibly	ts to solve the problem until [ calm. Staff should also refrain				,
	I from getting into an	argument with (Client #1)				
	when he is visibly up	pset/angry."				
	A review of the facil	[45.7] [-4] . I				
	investigation was co	ity's internal incident onducted on December 19,				
	2006 by the Incident	t Review Committee (IRC)				
	I ne IRC review con	cluded that on November 20				
	Vending machine to	d Client #1 access to a purchase several items that			}	
	were not permitted of	on his 1800 calorie. Low				
-	Cholesterol Diet for a	Control weight. Another staff	}			
	who noted that the c	lient had the food items not				•
	which lead to his bet	ook them from the client navioral outburst. The		See W193 Pg 25		1
	behavioral episode le	ed to the Mandt restraint the	•		1	
	police being called a	nd the client being				
	training for staff to in	ays. The IRC recommended clude avoiding power				
	struggles and also to	discuss taking the personal				
	items the client was a	allowed to purchase At the		•		
	I time of the incident, t	here was no evidence each		•		l
	strategies and interve	rained on the proactive entions included in Client #1	•	•		
	s behavior support p	lan to address his			f	
W 202	maladaptive behavior	<del>.</del>				
VV 202	DISCHARGE	IISSIONS, TRANSFERS,	W 202		:	
					'	·
	If a client is to be either	er transferred or discharged,				
	the racility must provid	de a reasonable time to		See W159 #5		
}	prepare the client and quardian for the trans-	his or her parents or fer or discharge (except in				
	emergencies).	or or discriarge (except in		•		
	This STANDARD :	ot mat will				
i	THE STANDARD IS IN	ot met as evidenced by:	1		ſ	- 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/28/2007

PRINTED: 02/28/2007 FORM APPROVED OMB NO 0938 0301

STATEME	ENT OF DEFICIENCIES	- & WEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	OMB NO	0. 0938-039
AND PLAI	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) Mt A. BUIL	JLTIPLE CONSTRUCTION  DING	(X3) DATE S	SURVEY
		09G002	B. WIN	G	-	
NAME O	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			02/0	09/2007
NCC				STREET ADDRESS, CITY, STATE, ZIP 6200 2ND STREET, NW WASHINGTON, DC 20011	CODE	
(X4) ID PREFIX `TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	MOULD BE Chose	(X5) COMPLETION DATE
W 20.	Based on interview failed to provide evi a reasonable amou transfer or discharg the eight clients (Clients interview with Clients 51 PM revealed the apartment on Febru	and record review, the facility dence that clients were given nt of time to prepare for e from the facility, for one of ent #2) included in the sample ::  #2 on February 7, 2007 at 3: client went to see her new ary 6, 2007. The client		A traditional plan was deve attachment). Also see respo	loped. (See Inse to W159 #5	
W 242	Interview was condu Retardation Professi 2007 to ascertain inf not a transition plant identified Client #2's goals to be attained of of the facility. The Quality had just signed a form acceptance of the neteransferred. At the tiffacility failed to provide plan had been developed to the individual progration of the individual progrations clients who lack skills essential for principle individual progration of the individual progration of the individual progrations of the individual	w location and request to be me survey, however, the de evidence that a transition oped for Client #2  IVIDUAL PROGRAM PLAN m plan must include, for them, training in personal wacy and independence (	W 242	QMRP will meet with the ID discuss the concern by the su However, the client has dem she can perform this task wit gestures.  See W 120 Pg 6 #2	irveyor.	

STATEMEN	T OF DEFICIENCIES		(X2) M	ULTIPLE CONSTRUCTION		OMB NO. 0938-039	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUI		(X3) DATE . COMPL		
<u>-</u>		09G002	B. WIN	G			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 6200 2ND STREET, NW WASHINGTON, DO. 000011	02/0	09/2007	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	<del></del>	WASHINGTON, DC 20011			
PREFIX TAG	(EACH DEFICIENC)	Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION ) REFERENCED TO THE APPROI	SHOULD BE SEEN	(X5) COMPLETION DATE	
W 242	Continued From pa	ge 27	W 2	42			
	review, the facility for personal hygiene shone of eight clients. The finding includes [Cross refer to W12 ensure that a progration #6 to wipe he materials (i.e. paper 483.440(c)(6)(vi) INI	0]. The facility failed to am was developed to train remouth using appropriate towels, napkins, tissue). DIVIDUAL PROGRAM PLAN am plan must include	W 24	7 See W120 pg. 6	#2		
t t t t t t a 7 sc ric w	pased on observation review, the facility fail encouraged to make management in their their capability for eigolients #1, #2, #3, #4 in the sample.  The findings include:  The facility failed the opportunity to mail the opportunity to mail the copy beginning at serving the clients the ce, green beans, flavorater. There were not pepper offered or p	not met as evidenced by: n, interview, and record led to ensure clients were choices and increase self- environment to the extent of th of the eight clients ( 1, #5, #6, #7 and #8) included o ensure clients were given ke choices.  evening meal on February 5:12 PM revealed staff ir meal (stewed beef with vored milk, fruit cocktail and condiments, such as salt resent on the table for the mally, staff was observed to		a. QMRP conducted training style dining protocol on 3/14 Additional training will occu Training will be scheduled ar	/07.	3/14/07	

DEPAR	RTMENT OF HEALTI	H AND HUMAN SERVICES			19	RINTEC	02/28/200
CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES	·			FORM	1 APPROVE
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	<u> </u>				02/0	9/2007
NCC				'	REET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	<del></del>		WASHINGTON, DC 20011		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE C REFERENCED TO THE APPROPRIATE DEFIC		(X5) COMPLETION DATE
W 247	Continued From pa	ge 28	W 2				
<u>-</u>	scoop Client #2's fo on her plate. At the failed to ensure clie	ood from a bowl, and place it time of the survey, the facility nts were provided the choices during mealtimes	VV 2	<u>'</u> 4 <i>(</i>			
	eating the food that plates. Further obsewere no condiments offered during the distaff revealed that that condiments wer offered during mealt	servation on February 06, 8, #7 and #8 were observed had been served on their ervation revealed that there is provided on the table or linner meal. Interview with his was a daily practice and re not provided on the table or lime. There was no evidence I been provided for the clients.			b. See W 189 pg 21 #8		3/13/07
	Observation on Febrapproximately 3:17 Febraph Mental Retardation Febraph Mental Retardation Febraph Mental Retardation Febraph Mental Retardation Febraph Mental Retardation Febraph Mental Febraph Mental Me	uary 07, 2007, at PM revealed that the Qualified Professional (QMRP) verbally it to Client #7 to point to what reral picture symbol cards, ed to point to a picture of a than got up from her chair table and picked up a small of orange juice. Staff took ainer from the client, stating to orange juice. There was noice of an appropriate food lient from which to select.			2. Client # 7's primary care physician ruled out allergic reaction to orange juic see attached nursing note on 2/8/07. Whallergies and or/dietary restrictions are noted alternative choices are provided.	ce	3/14/07
3 d C 2 w	i. The facility failed to lifferent types of silve Observation of the din 007, Clients # 3 was rith a plastic fork. Th is fingers to push the	Offer clients a choice of			See W 189 pg 21 #8  3. Food services will make proper utensit available during meals.  See W 159 #8		3/13/07

STATE	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	[(X2) b	41 // T	215	OMB NO	0.0938-0	39 ·
ANDP	LAN OF CORRECTION	IDENTIFICATION NUMBER	A BU		PLE CONSTRUCTION G	(X3) DATE : COMPL	SURVEY	<del></del> -
L		09G002	B Wii	NG _		1		
NAME	OF PROVIDER OR SUPPLIER	<u> </u>				02/09/2007		
NC	С			6.	EET ADDRESS, CITY, STATE, ZIP CODE 200 2ND STREET, NW			
(X4)	ID SUMMARY STA	ATEMENT OF DEFICIENCIES			ASHINGTON, DC 20011			
PRE TA	CIA : (CACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	PROVIDER'S PLAN OF CORRECT  FREFIX  (EACH CORRECTIVE ACTION SHOULD  REFERENCED TO THE APPROPRIATE I			(XS) COMPLETI DATE	
W 2	Continued From pa	ge 29	1015					
W 2	clients in the sample meal using plasticwed dinner. Interview with 7, 2007 at 6:21 PM provided metal silve meals. There was a offered a choice of 483.440(d)(1) PROCEAS soon as the interformulated a client's each client must recent treatment program of	e were observed to eat their are during the same during the the nutritionist on February revealed the clients should be tware with which to eat their no evidence the clients were eating utensils at mealtime. GRAM IMPLEMENTATION disciplinary team has individual program plan, eive a continuous active consisting of needed.	W 2		3. See W 159 pg 21 #8	;		
	This STANDARD is Based on observation verification, the facility one out of eight client and consistently encolearning opportunities their skill levels for the survey (Clients #7, #9). The findings include:  1. The facility staff fail.	to maintain or enhance ree of fifteen clients in the land #10).						
	I Mental Retardation Pro	's (BSP) as written.		1	1. Staff was retrained on client #7's I plan on 3/15/07. See W 159 pg 20 #4	BSP :	3/15/07	

	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	I TIOLE COMPANY	OMB NO	OMB NO. 0938-039	
		OF CORRECTION	IDENTIFICATION NUMBER	A BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY	
ı		<del></del> _	09G002	B WIN	3	-		
	NAME OF F	PROVIDER OR SUPPLIER		<del></del>		02/0	09/2007	
I	NCC				STREET ADDRESS, CITY, STATE, ZIP 6200 2ND STREET, NW	CODE		
l	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<del></del> _	WASHINGTON, DC 20011			
	PRÉFIX TAG	I TEMOR DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP		(X5) COMPLETION DATE	
	W 249	Continued From pag	je 30	W 24			·	
		she wanted from set Client #7 was observed food item. The client and walked over to a four ounce container the orange juice contained that she was allergic returned to her chair client that was sitting. The client that was acclients in the vicinity of the container of the client that was acclients in the vicinity of the container of the client that was acclients in the vicinity of the client of the client that was acclients in the vicinity of the client of the	veral picture symbol cards. ved to point to a picture of a than got up from her chair a table and picked up a small of orange juice. Staff took tainer from the client, stating to orange juice. Client #7, and head butted another on a sofa next to her chair. ssaulted and several other were removed from the area.	W 24	1. Staff was retrained on clie Behavior Support Plan on 3/	ent #7's /15/07	3/15/07	
	t E c 22 b b o a lo fe re pl be ar re ev as	activities. Interview withey had been trained Behavior Support Plat dated October 13, 200 2008) revealed that the behaviors that include outling, hitting, kicking appositional behavior, ittention span, poor cow frustration tolerance as smearing, and teaview revealed that if hysically aggressive the directed to complete the inforcement of target vidence that staff implies written.	client in any further ith the staff revealed that I on the Client #7 's I (BSP). Review of the BSP I (Expiration date January) I e client has targeted I physical aggression( head I), self-injurious behavior, hyperactivity, short I procentration, distractibility, I pe, poor impulse control, I mper tantrums. Further I the client becomes I wards others she should I program activities after I avoid inappropriate I behavior. There was no I lemented Client #7 was		See W159 #4			
	se	rticipate in his training lf-help skills in eating	Drogram to develop their			e de la companya de l		
4		2.99) Browing Variance	and opposited to teed					
	VIIIO-Z30/117				·	1		

DEPAR CENTE	TMENT OF HEALTI	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTE FOR	D: 02/28/200 M APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A BUILO	TIPLE CONSTRUCTION	OMB NO	<u>0. 0938-039</u>
<u></u>	_	09G002	B WING			
NAME OF	PROVIDER OR SUPPLIER		<del>-</del>	TOPET 100000	02/	09/2007
NCC			l a	TREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	3.00.000	(X5) COMPLETION DATE
W 249	Continued From pa	ne 31				
	- Thirties of Front pa		W 24	9		
	using a built-up har indicated the client hand-over-hand ass to Client #9's individed October 24, 2006, seating skills. The observation of the special feed himself with 10 trials." A second 9, 2007 at breakfast client. Interview with participates in the fetime is available and for his school which facility. At the time on evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence client we hand some evidence evidence evidence evidence of the evidence evi	fast from a sectioned plate adle spoon. Interview with staff should participate by allowing sistance from staff. According dual program plan (IPP) dated he has a goal to improve his objective states "When given and a plate of food, [Client #9] on, with assistance from staff th 50% independence for 8 of meal observation on February revealed staff feeding the on the staff indicated the client redding process when more if he does not have to leave is located away from the fithe observation, there was as encouraged to participate we designed to improve his		2. QMRP will retrain staff on clie feeding protocol by 3/20/07	nt #9	3/20/07
	reed Client #10 his a built-up handle spool nterview with staff fecilent needs assistant and liquid foods. Interview of the client's all liquids other than youngh several times a econd meal observateakfast revealed a staff indicated the client in the same mataff indicated the client in the fecilent in the same mataff indicated the client in the same mataff indicat	pureed breakfast using a pureed breakfast using a pureed breakfast using a pureed breakfast using a pureed breakfast using a pureed the ce to consume both pureed riview with staff and the meal protocol revealed the water were thickened to a pure thickened to a pure thin the client was observed to after finishing his meal. A atton on February 9, 2007 at different staff feeding the nner. Interview with the pure that a formal program to g program in the evenings, as enough time at other an opportunity help feed		3. QMRP will retrain staff on client feeding protocol by 3/20/07 (see att training sign in sheet)	#10's ached	3/20/07

himself. According to Client #10's individual

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MIN XID E CONTROLLED

PRINTED: 02/28/2007 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.  09G002			7	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391		
		IDENTIFICATION NUMBER.	1				(X3) DATE SURVEY COMPLETED		
		B Wi	B WING						
NAME OF PROVIDER OR SUPPLIER  N.C. C.			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW			09/2007	<u> </u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG  WASHINGTON, DC 20011  PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE		3 OC 600 - 4		-	
W 249	program plan (IPP) dated December 6, 2006, he has a goal to learn to use an adaptive spoon and to independently feed himself. The objective states "When provided with the appropriate materials, [Client #10] will scoop food using an adaptive spoon and feed himself with 25% independence for two consecutive months by December 5, 2007. During the morning observations on the aforementioned dates, there was no evidence the client was provided opportunities to participate in his feeding program to improve his self- help skill in eating.		W 2		sec W249 # 3 pg. 32		3/20/07		
	Based on observation review, the facility fail Client #10's s progres Plan (IPP) participate from an adaptive spoon. The finding includes:  On February 7, 2007, Client #10 a pureed be nandle spoon. Further with staff feeding the client goods. Interview the client's meal protoother than water were	not met as evidenced by: n, interview and record led to accurately monitor ss in his Individual Program on in hand over hand eating on.  staff was observed to feed reakfast using a built-up r observation and interview client revealed the client onsume both pureed and with staff and the review of col revealed the all liquids thickened to a honey t was observed to cough			QMRP will retrain staff on data coll as it relates to this program by 3/20/	ection 07.	3/20/07		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 **CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING COMPLETED 8 WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ŃÇÇ 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 1D PROVIDER'S PLAN OF CORRECTION PREEIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 252 Continued From page 33 W 252 several times after finishing his meal. A second meal observation on February 9, 2007 at breakfast revealed a different staff feeding the See W 252 on pg 33 client in the same manner. Interview with the 3/20/07 staff indicated the client has a formal program to participate in a feeding program using hand over hand assistance in the evenings, however the program was implemented at other meals if there was enough time. According to Client #10's individual program plan (IPP) dated December 6, 2006, he has a goal to learn to use an adaptive spoon and to independently feed himself. The objective states "When provided with the appropriate materials, [ Client #10] will scoop food using an adaptive spoon and feed himself with 25% independence for two consecutive months by December 5, 2007 The review of the strategy for implementing Client #10's feeding program revealed, "If the client refuses to scoop his food, provide with hand over hand assistance .... During each meal evaluate only the first 10 scoops .... If [client refuses to participate in the program and staff attempts to get him to participate have failed after 5 minutes, staff should feed him." According to the schedule, the program should be implemented daily at 5:30 PM for thirty minutes, however the data should be recorded on Monday through Friday only. Staff should document the level of assistance required to get the client to consume each scoop of food until 10 scoops have been consumed. The review of program data for January 2007 indicated the client required handover-hand assistance on 14 of 23 days. On the other 8 of 23 days, the record failed to document any level of performance in the eating program.

PRINTED: 02/28/2007 FORM APPROVED OMB NO. 0938,0301

STATEME	ENT OF DEFICIENCIES	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		000000	B WIN					
NAME OF	F PROVIDER OR SUPPLIER	09G002				02	(09/2007	
l	L LYONDER OK SUPPLIEF	₹		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1	03/2001	
NCC				62	200 2ND STREET, NW			
				_ W	ASHINGTON, DC 20011			
(X4) ID PREFIX			ID		PROVIDER'S PLAN OF CORRECTION		(95)	
-TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG"		(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	DC 04	COMPLETION	
<del></del>	<del> </del>					EFICIENCY)	DATE	
W 25			W 2	52			<del> </del>	
	There was no evid	dence that program data was			See W252 pg. 33, 34			
	Qocumented at the	e frequency required by the			осе w 252 pg. 53, 34		3/20/07	
	performance.	ately measure the client's						
W 259		483.440(f)(2) PROGRAM MONITORING &						
	CHANGE	OTO AM MONTONING &	W 259					
					•			
	At least annually, t	he comprehensive functional				j		
( <b>a</b> )	the interdisciplinan	ch client must be reviewed by y team for relevancy and				:		
•	updated as needed	d.						
						1		
	This STANDARD	is not met as evidenced by:						
	verification the fac	ion, interviews, and record illity failed to ensure the						
	comprehensive fun	ictional assessment was						
	reviewed and upda	ted to address the specific				•		
	benavioral manage	ment needs for one of eight			•			
	clients in the sampl	e. (Client #8)	1		·			
	The finding include:	S:						
	On February 6, 200	7 Client #0	1	-				
	playing a game of b	7, Client #8 was observed asketball with staff and two						
	ciner clients. Furth	er observation revealed that			NCCD	1	ł	
	the client became a	RQIV when the baskethall was			NCC Psychologist completed currer for client # 8 and trained to the second seco	it BSP	1	
	not passed to him in	nmediately. Staff verbally ro-			for client # 8 and trained staff on the 3-9-07 (see attachment)	BSP	3/9/07	
ı	the Qualified Mental	nd he complied. Interview with Retardation Professional (			( see attachment)			
j	QMRP) revealed the	at Client #8 has a Behavior		1		1	i	
j	Support Plan's (BSP	), however the plan was not				ł	1	
ł	current. Record verif	ication revealed that Client #			•			
	os last BSP expired	on June 7, 2006 Further						
1	notified the psychological	vealed that the QMRP had gist in writing regarding the						
1	expired BSP. There	Was no documented				1		
1.	evidence that the clie	ent had a current BSP				1	1	
VV 262	483.440(f)(3)(i) PRO	GRAM MONITORING &	W 262					
'	CHANGE		202			1		

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTER	D: 02/28/200
CENT	<u>ERS FOR MEDICARE</u>	& MEDICAID SERVICES			FORM	1 APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MI	IULTIPLE CONSTRUCTION LDING	OMB NO (X3) DATE S COMPL		
		09G002	B WIN	4G		
NAME OF	PROVIDER OR SUPPLIER		<del></del> -		02/0	9/2007
NCC				STREET ADDRESS, CITY, STATE, ZIP COD 6200 2ND STREET, NW WASHINGTON, DC 20011	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CODE	U D DE A	(X5) COMPLETION DATE
W 262	Continued From page	ge 35	W 26	62		
	monitor individual pr	uld review, approve, and ograms designed to manage ior and other programs that, committee, involve risks to rights.				
	Committee (HRC) co	not met as evidenced by: ensure the Human Rights anducted a timely review of of Restraint for Clients #1.				
	The finding includes:					
	agitated, non-complia school property. After respond to staff effort placed in a one perso for approximately four be physically and vert psychologist, nurse at Record review revealed May 3, 2006 for Haldo	ts to calm him, the client was on two arm Mandt Restraint r minutes, but continued to pally aggressive. The client's nd the PCP was notified. Ed a physician's order dated of 5 mg IM. According to a ne same date.		See W149 #3 Pg 12		
	Interview and record revealed the incident revealed the incident review of Emergency on May 16, 2006. The /Feedback Form indicants restraint/ rights Restrictly was	eview on February 9, 2007 manager completed the Restrictive Procedure Use review of the HRC Minutes ated the Emergency Use of ction (Physical and on not reviewed by the HRC 24, 2006. According to the				

Emergency Guidelines and Notifications in the Restraint Report, the HRC Chair shall be notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	. (X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039		
JANU FOS	N OF CORRECTION	IDENTIFICATION NUMBER	A BUI			(X3) DATE COMPL	SURVEY	
<u> </u>		09G002	B. Win	۷G		1		
NAME OF	F PROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE	02/0	09/2007	
(X4) ID		ATEMENT OF DEFICIENCIES	<del>,</del>	_ <del></del>	ASHINGTON, DC 20011			
PREFIX TAG	/ CACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI. TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D			
W 26	2 Continued From pa	ige 36	10/ 0			<del></del>		
W 264	on the next busines restraint. There was of restrictive technic	ss day of the emergency s no evidence a timely review ques used on Client #1 ROGRAM MONITORING &	W 2					
•	programs as they re restraints, time-out or or noxious stimuli, c behavior, protection	uld review, monitor and make acility about its practices and elate to drug usage, physical rooms, application of painful ontrol of inappropriate of client rights and the committee believes need						
	review, the facility fai make suggestions re on the main exit door	not met as evidenced by: n, staff interview and record led to review, approve or garding the use of the locks s to the residential facility.			Sec W104 #3		3/15/07	
	locked. Although inte during the survey, inc door are not locked do	On February 6, 2007 at 7: loors were observed to be rview with several staff licated that at times the uring the day, the doors ain locked throughout the	·		· ,			
i F P	prevent clients who has the prevent clients who has becondence from attended the RPD in	idential Program Director ( e locks were installed to ve targeted behavior of empting to exit the facility. Indicated that this practice individuals from entering						

STATEMEN	T OF DEFICIENCIES	CAL PROVIDENCE OF THE PROVIDE	<del></del>		OMB NO. 0938-0391		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
	_	09G002	B WING	5			
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	PTREET ADDRESS THE	02/09/2007		
NCC				STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW WASHINGTON, DC 20011	: _		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	ID BE CROSS   SOUTH		
W 264	Continued From page	ne 37	1 10/ 05				
_	the building. Furthe the Director of Qual- record verification fa facility's Human Rig reviewed or made s	ir interview with the RPD and ity Improvement (QI)and the ided to provide evidence the hts Committee (HRC) had uggestions regarding the ide locks on the doors at the	W 26	Cross reference W104 #3			
W 322	facility. 483.460(a)(3) PHYS		W 32	2			
	The facility must pro general medical care	vide or obtain preventive and a.					
	Based on observation review the facility fail preventive and general implement medical proclients in the sample. The findings include:  1. The Primary Care Client #7's weight lost than the sample of Client #7's weight lost than the facility's nursing to the primary Care Physicists and the primary Care Physicists and the sample of the seighed 193 pounds weighed 176 pounds that Client #7 had lost of the weight chart included the pounds in the primary staff acknowled the pounds in the primary staff acknowled the primary staff acknowled the primary of the weight and the primary staff acknowled the primary of the weight and the primary of the prima	Physician failed to assess stimely.  Staff failed to notify the an (PCP) of Client #7's us in January, 2007. Review chart revealed that the client in December, 2006, and in January, 2007. revealing to 17 pounds. Further review licated that the client in February 2007. The edged that the PCP was not eight loss in a timely manner.		1. The primary physicians progress entry Of 2/8/07 reflects timely respond a weight loss that was desired a reported as typical for medication to Geodon. (See attachment #3 A a Medical staff will follow their polinform the Nutritionist when a weight change of 5lbs or greater occurs demonthly weighing.	ponse nd change and B): icy to ight		

STATEMENT OF DEFICIENCIES	W		<del></del>	OWR NO	<u>. 0938-039</u>
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE S COMPL(	_
	09G002	B WIN	3	02/0	10/2007
NAME OF PROVIDER OR SUPPLIER		_,	STREET ADDRESS SITUATION		9/2007
NCC			STREET ADDRESS, CITY, STATE, ZIP 6200 2ND STREET, NW	CODE	
			WASHINGTON, DC 20011		
PREFIX   (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOLN DIRE CROSS	(X5) COMPLETION DATE
Review of the policy that the PCP is to be loss of a minimum of evidence that the PC client's weight loss if 2007. There was no loss was addressed.  2. The facility's med follow-up ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  Review of the ophthalmood as evidenced by:  3. The facility's medicate as evidenced by:  3. The facility's medicate as evidenced by:  3. The facility's medicate as evidenced by:  3. The facility's medicate as evidenced by:  3. The facility's medicate as evidenced by:  4. The review of Client and the results of Client and the evidence by:  4. The review of Client and the evidence by:  4. The review of Client and the evidence by:  4. The review of Client and the evidence by:  4. The review of Client and the evidence by:  4. The review of Client and the evidence by:  4. The review of Client and the evidence by:  5. The review of Client and the evidence by:  6. The review of Client and the evidence by:  6. The review of Client and the evidence by:  7. The review of Client and the evidence by:  8. The facility's medicate by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The review of Client and the evidence by:  9. The	Client #7's weight loss.  Y entitled "Weights" revealed e notified of any weight gain or of two pounds. There was no CP were made aware of the n January 2007 until February of evidence the client's weight timely by the PCP.  Ical services failed to obtain a allogy appointment for Client #  almology consult dated evealed that a follow-up commended for Client #7 in eview revealed that the indicated that the eye ited and that the client had ew and record review ent did not go to back to the	W 3:	2. Client #7 participated in a Ophthalmalogy appointmen (see attachment) The medical diary will be correctly utilize that appointments will be manner.  3. The medical appointment amended to include a promp on which additional labs or medical appointment were of medical attachment)	at on 3/13/07 al appointment and to ensure hade in a timely  at diary was of for the date	3/13/07

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING COMPLETED B WING 09G002 02/09/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG W 331 483.460(c) NURSING SERVICES W 331 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record Cross reference W 149 Page 13 (Attachment # 1 and 2) review the facility failed to ensure nursing services in accordance with the needs of two clients in the survey. (Clients #7 and #9) The findings include: 1. Cross reference response to W 322 #1 page 38 attachment A and 3B, and W 338 The facility's nursing services failed to inform pg 41. the PCP of Client #7's weight loss. Review of Client #7's weight chart revealed that the client weighed 193 pounds in December, 2006, and weighed 176 pounds in January, 2007. revealing that Client #7 had lost 17 pounds. Further review of the weight chart indicated that the client weighed 176 pounds in February, 2007.

Drugs" for Client #9.

The nursing staff acknowledged that the PCP was not made aware of the weight loss in a timely manner. Review of a nursing progress note dated February 6, 2007, revealed that the PCP was made aware of the Client #7's weight loss. Review of the policy entitled "Weights" revealed that the PCP is to be notified of any weight gain or loss of a minimum of two pounds. There was no evidence that the PCP were made aware of the

The facility's nursing services failed ensure that each medication that was wasted was disposed of in accordance with the policy on "Disposal of

Observation of the evening medication pass on

client's weight loss in January 2007.

STATEM AND PLA	NENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	OMB NO	OMB NO. 0938-039		
	TO CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE			
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NAME C	F PROVIDER OR SUPPLIER		<del></del>	0.70	02/	09/2007		
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(X4) II		ATEMENT OF DEFICIENCIES		WASHINGTON, DC 20011				
PREFI TAG	A I CACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG			(XS) COMPLETION DATE		
W 33	Continued From pa	nge 40		<del></del>	<del></del>			
W 338	February 6, 2007 re Practical Nurse (LP milliliters of Colace observation revealed approximately 2 mil a regular plastic line the LPN revealed th administered only 10 and that she had to medication. Review Drugs revealed that by the nurse adminis Medical Waste red by that the medication of the facility's policy.	evealed that the Licensed (N) prepared approximately 12 liquid for Client #9. Further and that the LPN poured liliters of the Colace liquid into a trash can. Interview with the color of the Policy of Colace liquid discard the excess of the policy on Disposal of wasted drugs shall be made stering the medication in the pag. There was no evidenced was discarded according to	W 3:	Cross reference W 149 Attachment (#1 and 2)	Page 13	3/8/07		
	review of their health any necessary action physician to address  This STANDARD is r Based on staff intervie facility's nursing servic follow-up on referrals needs of one of eight #7)  The finding includes: The facility's nursing services	st include, for those clients ng a medical care plan, a status which must result in (including referral to a client health problems).  not met as evidenced by: ew and record review, the ces falled to ensure timely in accordance with the clients in the sample. (Client ervices failed to implement						
1	Weights" that required the clients' health/medi	that the nurse to evaluate ical condition and notify the nurse to evaluate ical condition and notify the nursing staff	·					

STATEMEN	T OF DEFICIENCIES	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		N TIDLE COLUMN	OMB NO. 0938-039		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVĘY	
· · · · · · · · · · · · · · · · · · ·	<b></b>	09G002	B. WING	3	_		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, ÇITY, STATE, ZIP 6200 2ND STREET, NW	02/0 CODE	09/2007	
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W 338	Continued From pa	age 41	10/ 00				
	failed to notify the weight as evidence Review of Client #7 the client weighed	PCP of Client #7's change in	W 33	Cross reference W 322 r W331 page 40.	age 38 and	2/8/07	
W 362	Further review of the client weighed. The nursing staff at was not made awar manner. Review of dated February 6, 2 was made aware of Review of the policy that the PCP is to be loss of a minimum of evidence that the PC client's weight loss id 483.460(j)(1) DRUG A pharmacist with inteam must review that least quarterly.	it #7 had lost 17 pounds. It weight chart indicated that I 76 pounds in February, 2007. Icknowledged that the PCP I've of the weight loss in a timely I a nursing progress note I confirmed that the PCP I the Client #7's weight loss. I entitled "Weights" revealed I enotified of any weight gain or I fit two pounds. There was no I confirmed ware of the I January 2007. I REGIMEN REVIEW I put from the interdisciplinary I e drug regimen of each client	W 362	Cross reference W 322 pg 38	and W 331 pg		
to   to	pased on interview a o ensure that the ph egimens quarterly fo	not met as evidenced by: nd record, the facility failed armacist reviewed the drug or eight of eight clients in the #2, #3, #4, #5,#6, #7 and #8					
Т	he findings include:						
pi	our revealed the phi rescribed medication	pervisory RN on February 8, armacist reviews the clients' as quarterly. The review of eview forms in the clients'	·				

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	RICLIA (X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING			(X3) DATE SURVEY COMPLETED		
		09G002	B. WIN	1G				
NAME OF	PROVIDER OR SUPPLIER					02	<u>//09/20</u> 07	
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W 362	records indicated the medications for Clie and #8 were conducted review of the agency a record of each residual be kept in the residual processing the second of each residual processing the record of each residual processing the record of each residual processing the record of each residual processing the record of each record of each residual processing the record of each record of the reco	e pharmacist reviews of the nts #1, #2, #3, #4, #5, #6, #7 eted on August 9, 2006. The y's Medication Policy revealed ident's drug regimen review resident's medical chart nce the clients' drug regimens ast quarterly.	W 3		Pharmacy reviews were conducted 11/20/06. Format for pharmacist documentation changed since mer Omnicare see attachment 5a and 5	ger with	11/20/06	
	An individual medication administration record must be maintained for each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain medication administration records (MAR) to documenting the administration of medications for one of the eight clients in the sample (Client #1).				Nurses received training on "Back to Basics Pharmacy". On 3/8/07 and have reviewed current medication policy (see attachments #1&2)		3/8/07	
;	each medication admidocumented on the Miceord (MAR).  The review of an unusual May 3, 2006 revealed mg for aggressive belourse and the review 2007 revealed a physical progress on the same administered at 2:20 Fithe nurse and the reviewealed no evidence	services failed to ensure that inistered to Client #1 was fedication Administration sual incident report dated Client #1 received Haldol 5 navior. Interview with the of records on February 9, ician's order dated May 3, IM. According to a nursing date, Haldol 5 mg. IM was PM. Further interview with ew May 2006 MAR nursing services ensured was documented on the					·	

ı	STATEMEN	IT OF DEFICIENCIES	(XI) PROMER OF THE			OMB 1	<u>40. 0938-0</u>	30
	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DAT	E SURVEY	<u>5</u> 5
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	W 365	Continued From pag	ne 43	101.20				
	W 429	MAR in accordance	with nursing best practices. ATING AND VENTILATION	W 36				
		The facility must ma	intain the temperature and					
••		review, the facility fai	not met as evidenced by: n, interview and record led to maintain the normal comfort range in the		;			
		The findings include:			·			
		The facility failed to n within a normal comfo for Clients #2, #6 and	naintain the temperature ort range within a living unit the hallways.					
	t t t t t t t t t t t t t t t t t t t	the client's room felt of from the crevices around the frames of inspection. Interview february 6, 2007 at 6, slept with her sweater outdoor temperatures from February 6, 2007 a Veather Service for the Qualified Mental Retarwas immediately info	caled the air temperature in cold. Cold air was coming and the door frame and from the windows upon conducted with Client #2 on 27 PM revealed the client on. Record review revealed of 10 degrees Farenheit at the Fahrenheit at 3:03 PM, is measured by the National are metropolitan area. The redation Professional (QMRP) med of the condition of		a. The facilities department will an equipment check and weath occurs in fall prior to winter an prior to summer. Cross reference #3 on pg 2.	er proofing	2/9/07	
_	p th	allent #2's bedroom are ersonnel. A maintena hereafter observed plan prevent the air from	and called for maintenance ance person was shortly					

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII	TIPLE CONTROL	OMB NO. 0938-039		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WASHINGTON, DC 20011			
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W 429	Continued From pa	ge 44	W 429			<del>-</del>	
	crew was observed again attending to the time of the survey, the temperature of Clien	on February 7 and 8, 2007 ne cold air problem. At the the facility failed to ensure the nt #2's bedroom was comfortable range at all times	VV 420		•		
	b. Observations of Conducted on Febru 6:13 PM revealed the The ceiling tile was approximately the sillair was entering the	Client #2 and #6's living room lary 6, 2007 at approximately at the room felt very cold. observed to have a hole ze of a tennis ball where cold room. On February 7, 2007 d with tape to prevent the air		b. See W 429 item a.	,	2/9/07	
	hallway near the nur- clients' living unit. Ob- double doors leading revealed cold air was the doors. Record re- temperature range of degrees Fahrenheit ti measured by the Nat the metropolitan area on February 8, 2007.	207 at 6:30 PM, the content to be cold in the sing station and near the observation of the exterior into to the main hallway into to the main hallway into to the main hallway in the series of the outdoor of the february 7, 2007 was 16 to 29 degrees Fahrenheit as it is conal Weather Service for an Observation and interview revealed these exterior by the maintenance crew to		c. See W 429 item a.	,	2/9/07	
e c c t	prevent most of the a d. On February 9, 200 air entering the facility entrance doors in the dining rooms. This inf he Residential Progra outdoor temperatures anged from 17 degre	ir from entering.  77, the surveyors noted cold or around the double hallway adjacent to the formation was reported it to am Manager (RPM). The		d. See W 429 item a.		2/9/07	

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Levery			OMB_NO_0938-0391		
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NAME OF	PROVIDER OR SUPPLIER		·	6	REET ADDRESS, CITY, STATE, ZIP CODE 200 2ND STREET, NW VASHINGTON, DC 20011		09/2007	
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W 429	Weather Service for Interview with staff chilly because it was Further interview with supervisor however temperatures in the reported to him. The have been repaired prevent the cold air. There was no evide had been maintaine at all times.  483.470(g)(2) SPACT The facility must fund the ach clients to choices about the ushearing and other coand other devices id.	r the metropolitan area. indicated the hallways were is unusually cold outside. th the building maintenance revealed the chilfy building had not been doors were observed to on February 9, 2007 to from entering the building. Ince the building temperatures d with a normal comfort range OE AND EQUIPMENT  Thish, maintain in good repair, use and to make informed the of dentures, eyeglasses, formunications aids braces	W 4					
	Based on observation review, the facility fail were maintained in gethe survey (Clients # ensure one client (Clifor his glasses; failed #2 and #4) was trained failed to ensure adaptived as approved by two clients (Clients #8). The findings include:  1. The facility failed to review the failed to the facility failed to t	not met as evidenced by: n, interview and record led to ensure wheelchairs cod repair for three clients in 5, #9, and #10; failed to ient #1) was trained to care to ensure two clients (Client ed to wear their glasses; and tive feeding devices were the interdisciplinary team for 5 and #10).						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA									
ı	AND PLA	IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	Ιυμτι	PLE CONSTRUCTION			
J			IDENTIFICATION NUMBER	A. BUII					Y
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ŀ	NAME C	F PROVIDER OR SUPPLIER	09G002	5 74114	_		0	2/00/20	O. 7
l				Ī	STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	2109120	<u> </u>
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H		<del></del>			V	VASHINGTON, DC 20011			
	(X4) I( PREFI	SUMMARY STA  X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECT	TION.	<del></del>	
l	TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG		LECTOR CORRECTIVE ACTION COOLS	n=	MB NO. 0938-039 3) DATE SURVEY COMPLETED  02/09/2007  ROSS- COMPLETION DATE  ent of the content	
L						REFERENCED TO THE APPROPRIATE D	EFICIENC	Y) [	ATE
	W 43	6 Continued From page	ge 46	W 4	26				
		to wear their eyegla		""	30	•		'	
		Į.							
		a. Evening observat	tions conducted on February 6						
		souinting while work	05 PM revealed Client #4			a. QMRP will implement a goal for	4-		
		Interview with the Re	king with an electronic device. esidential Counselor revealed			#4 to learn to care for his glasses by	Client	}	
		Inat Client #4 wears	Glasses but exhibit behaviore			3/20/07. The staff will be trained or	Client	3/2	0/07
		If asked to wear ther	M. Staff was observed at no	Ì		#4's goal by 3/20/07 (see attachmen	it for	<u> </u>	
		<ul> <li>ume to encourage C</li> </ul>	lient #4 to wear his			sign-in sheet)			
		eyeglasses.						1	
		Interview with the Qu	ualified Mental Retardation						
		☐ Professional (QMRP	) on February 9, 2007		-			j	·
		confirmed that Client	t#4 has glasses and						
		revealed she should	be encouraged to wear them						
		reveryday. Further in	terview with the QMRP #4 had not been taught to use						l
		and make informed of	decisions about his					1	
		eyeglasses. The QN	IRP indicated that the			•		.	
		residential staff had r	not been trained on the use						1
		of Client #4 's glasse	es.						
		Record verification of	Client #4's avec						ĺ
		physician's orders on	February 8, 2007 at 10:20			•			
		Aivi revealed a treatm	ient, "Glasses Everyday"		Ι,	Nurses = 111	1	ĺ	
		I nere was no evidend	ce that a system had been			Nurses will include glasses as a treati	nent		
		established to encour	age Client #4 to wear his			on the MAR. Documentation of the N will occur daily.	1AR	3/21	07
		glasses as recommer	naea.			y.			*
		b. Observation of Clie	nt #2 on February 7, 2007						
		at 3:18 PM revealed the	he client was being assisted !						
		l by staπ to complete he	er program objective (					]	- 1
		Client #2 on Fabrure	clock). Interview with						
		Client #2 on February revealed the client had	1, 2007 at 3:27 PM						
		in her room. The clien	d eyeglasses, but they were nt indicated that the glasses		1	O. Cross reference VII 4 50 110	į.		- 1
		were used for reading.	Confinued interview with		`	b. Cross reference W 159 #9	,		
	Ì	the client revealed the	client did not take them to				! !		1
	1	her day treatment prog	gram because she forgot			•	'		- 1
_			-		ı		1		J

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING COMPLETED B WING 09G002 02/09/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW NCC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 436 Continued From page 47 W 436 them. Review of Client #2 's habilitation records on February 8, 2007 failed to provide evidence of a Client # 2 does not need to wear glasses training program to assist the client with wearing see 159 #9 her eyeglasses. At the time of the survey, the 3/14/07 facility failed to provide evidence that Client #2 was being taught to wear her eyeglasses. 2. The facility failed to ensure that Client #1 was provided training to care for his eye glasses. 2. QMRP will implement a goal to teach On February 6, 2007, Client #1 was observed client #1 to care for his glasses by 3/16/07. working on a written project for school. On Staff will be trained on client #1's glasses February 7, 2007, Client #1 was observed solving protocol by 3/20/07. Psychologist will add 3/16/07 math problems in his classroom with his face "care for glasses" to client #1 privledge close to his paper. Interview with the client and staff revealed he wears glasses but he broke his score card as a pro-social behavior new glasses. Staff showed the surveyor a pair of broken eyeglasses on February 9, 2007 which were waiting to be repaired and stated they belonged to Client #1. Further interview with the staff and the QMRP indicated client had broken several pairs of glasses. Interview with the QMRP indicated that attempts to train the client to care for his glasses had been unsuccessful. There was no evidence the client was currently involved in a training program to improve his skill in caring for his glasses.

3. The facility failed to ensure that the

maintained in good repair.

wheelchairs of Clients #5, #9 and #10 were

a. Observation of Client #5 's wheelchair on February 6, 2007 revealed the left arm rest had tears in it that exposed the yellow padding material. At the time of the survey, the facility failed to ensure Client #5's wheelchair was

3. Client # 5 wheel chair was repaired

3-1-07 see w159 #9

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED B WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X5) COMPLETION TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 436 Continued From page 48 W 436 maintained in good repair. b. On February 7, 2007 Client #9 was observed using his wheelchair with the left foot rest missing . The foot rest was observed laying on the floor. Interview with staff indicated the footrest would not stay on the chair. Approximately, thirty minutes later a staff was observed wheeling the client from the unit with both foot rest on the chair. On February 8, 2007 the client was again observed in his wheelchair with the left footrest off the chair. There was no evidence Client #9's wheelchair was maintained in good repair. c. Client #10 was observed using his wheelchair without the left foot rest on February 8, 2007.

4. The facility failed to ensure that Client #10 was provided with an adaptive cup recommended to increase his fluid intake.

Further observation of the chair revealed the part to which the footrest should be attached was

missing from the chair. Interview with staff caring for the client indicated she was not aware of how the chair became in disrepair. According to the clients Individual Support Plan (ISP), the wheelchair should be cleaned and checked for needed repairs or adjustments weekly. There was no evidence the client wheelchair was maintained

During meal observations on during breakfast on February 7 and 9, 2007. Client #10 was offered regular consistency water from a spoon. Observation and interview, as well as the record verification revealed the client is prescribed to receive all other liquids thickened to a honey consistency. Record review revealed a Safe Swallow Guide dated March 20, 2006 which

Cross reference W159 #9

QMRP ordered adaptive cup on 3/12/07. Staff trained on his protocol on 3/12/07. (see sign in sheet attachment)

in good repair.

PRINTED: 02/28/2007 FORM APPROVED OMB NO. 0038-0304

STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Town		OMB NO. 0938-039		
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER	A BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY	
<u></u>		09G002	B. WING				
NAME OF	F PROVIDER OR SUPPLIER		s	GTREET ADDRESS, CITY, STATE, ZIP COI	<b>02/0</b> DE	9/2007	
(X4) ID PREFIX _TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	4455	(X5) COMPLETION DATE	
W 436	recommended to g review of an Occup noted dated Januar was tested on two a his water intake (a cup with a control of the client appeared cup with minimal sp caretaker to control Interview with the Q indicated that she was recommendation for additional follow-up the time of the survetor the client's use. 483.470(I)(1) INFEOT There must be an accommendation, control, and communicable of the survetor that the communicable of the survetor that the communicable of the survetor that the communicable of the survetor that the communicable of the survetor that the communication of the control were that the communication control were the communication control were the communication of the communication control were the communication of the communication control were the communication control were the communication control were communication control were communication control were communication control were communication control were communication control were communicated to the communication control were communicated that the communication control were communicated to the communication control were communicated that the communication control were communicated that the communication control were communicated that the communication control contr	ive liquids by spoon. The pational Therapy progress by 4, 2007 revealed the client adaptive devices to optimize large dropper and an adaptive ow lid. the OT indicated that to benefit from the adaptive billage and the ability for the the flow of the liquid. MRP on February 9, 2007 has aware of the rather adaptive cup and that was needed to obtain it. At any, the cup was not available of the program for the add investigation of infection.	W 43	6			
	The facility failed to e provided with a napki	nsure that Client #6 was n or paper towel to wipe her ng a stained/soiled bib.					
	<ol> <li>2007 at 11:06 AM, treatment area seated a wall. The client was bib that was stained.</li> <li>a female staff membe</li> </ol>	#6 's day program February revealed the client in her don't a chair located against sobserved wearing a white At approximately 11:13 AM, or asked Client #6 to wipe did not respond. Shortly		Cross reference W112 #1			

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(200)			<u> </u>	<u>). 0938</u> -0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G002	B WI	NG _		,	
NAME OF	PROVIDER OR SUPPLIER			Γ_		02/0	9/2007
NCC	<u></u>			6	REET ADDRESS, CITY, STATE, ZIP CODE 200 2ND STREET, NW		-
(X4) ID	AT2 VAAMMU2	TEMENT OF DEFICIENCIES	<del></del>	<u> </u>	VASHINGTON, DC 20011		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE [	DE COORE	(X5) COMPLETION DATE
W 455	Continued From page	re 50	146				<u> </u>
W 474	thereafter, a male s wipe her mouth and touching her left har her mouth with the s Interview with the data Coordinator on the side and touching the appropriate paper towels). Intervesidential facility review mouth independ support staff offer Client#6 was provided.	taff member asked her to then prompted her by and directing her to wipe stained bib.  By program Support Staff same day at approximately 11 at there was no program in t #6 with wiping her mouth e materials (i.e. napkins, view with the QMRP at the wealed that Client #6 wipes ently. At no time did the lient #6 a napkin and/or paper buth. The was no evidence ed disposables (napkins or ich to clean her mouth when	W 4		Cross reference W112#1		
	Food must be served developmental level	f in a form consistent with the of the client.					
	review, the facility fail consistent with the declient for one of eight sample. (Client #6)  The finding includes:  Observations of the declient for one of eight sample. (Client #6)  The finding includes:  Observations of the declipation for the	not met as evidenced by: n, interview, and record led to ensure that a form evelopmental level of the clients included in the  inner meal conducted on 7 revealed that Client #6 dinner while feeding iew with the Residential 1, 2007 revealed that Client #					
							1

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI	I TIPLE COLUMN	OMB NO	0. 0938-0
THE PLANT	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY
	_	09G002	B WING	;		
NAME OF	PROVIDER OR SUPPLIER		<del> </del>		02/0	9/2007
NCC			9	STREET ADDRESS, CITY, STATE, ZIP CO 6200 2ND STREET, NW	DDE	
(X4) ID	CULTURE			WASHINGTON, DC 20011		
PREFIX TAG	TONOR DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR		(X5) COMPLET
W 474	Continued From pa	age 51				
W 484	Interview with the f Mental Retardation February 8, 2007 of Finely Chopped" di current Physician's Assessment dated 2007 at 2:33 PM re prescribed a 1200 of chopped diet. Ther receive her meals in prescribed. 483.480(d)(3) DININ	acility's dietician and Qualified a Professional (QMRP) on evealed that Client #6 is on a "et. Review of Client #6's Orders and Nutritional May 5, 2006 on February 8, vealed that Client #6 is calorie low cholesterol fine re was no evidence the client of the texture (fine chopped) as NG AREAS AND SERVICE uip areas with tables, chairs, dishes designed to most the	W 474	Food services staff dictician an care staff received a memo on regarding client # 6 correct dicattachment)		2/9/07
find C	railed to ensure dining the development of the development of the sample. The sample of the findings include:					
ea of the ro- b. ob	ating their prepared iffered condiments, sere were no condiments.  During breakfast on served to feed Client handle teaspoons.	#7 and #8 were observed meals. The clients were not uch as salt or pepper and ents available in the dining  February 7, 2007 staff was ats #9 and #10 using built- Interview with staff participates in feeding		A.Condiments will be provided of meals. Cross reference W159 # 8	during pg. 21	

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB MC	<i>J.</i> 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE	
			A BUIL	DING.	<del></del>	COMPL	-ETED
		09G002	B WING	G			
NAME OF	PROVIDER OR SUPPLIER		<del></del>			02/	09/2007
17/2011	CHOWNER OR SUPPLIER		] :	STREET	TADDRESS, CITY, STATE, ZIP CODE		
NCC					ZND STREET, NW		
<u> </u>	20000			WAS	SHINGTON, DC 20011		
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DÉFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	,   ,	PROVIDER'S PLAN OF CORRE	CTION	(X5)
~ YAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	R	(EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS- DEFICIENCY)	COMPLETION DATE
	<del></del>						
W 484	Continued From pa	ge 52	W 48	84			<del>                                     </del>
İ	himself. Hand-over	r hand assistance is					
	encouraged by resi	dential staff, however the		l P	B.QMRP will retrain staff on clic	ent#0	
	client's desire to as:	sist and level of participation is		fe	eeding protocol. Cross reference	: W249 #2	3/20/07
	inconsistent. At the	time of the observation, there				. 11 2 49 m2	
	opportunity to partic	e client was provided the pipate in self-feeding using the					
	adaptive spoon with	hand-over-assistance.					
		1			·		
	c. On February 7, 2	007 during breakfast, Client#					
•	10 was offered his ν	water from a spoon. Interview			<ul> <li>QMRP ordered adaptive cup</li> <li>12-07, cross reference W436 #</li> </ul>		3/12/07
	consuming liquids	the client has difficulty Further interview with staff		.ر	-12-07. cross reference w430 #	+	3/12/07
	and the review of th	e feeding protocol posted on					
	the bulletin board ar	nd the clients record revealed					
	the client should rec	ceive all liquids thickened to					
	noney consistency e	except water. Record					
	made for Client #10	d a recommendation was to have a special cup to					
	improve his fluid inta	ake on January 2007. At					
,	the time of the surve	ey, there was no evidence the		İ			
	special cup had bee	n provided for the client.					
W 488	483:480(d)(4) DININ	IG AREAS AND SERVICE	W 48	8			
	The facility must see	rupo that analy aligns at					
	manner consistent w	sure that each client eats in a vith his or her developmental		1			
	level.	Mar viis or vier developmental					
·	TI. 07.115						
	Paged on the	not met as evidenced by:				·	•
	of the activity school	n, staff interview, and review lle, the facility failed to assure					
	that eight out of eight	t clients in the sample ate in					
	a manner consistent	with his or her					
	developmental level.	(Clients #1, #2, #3, #4, #5,#					1
1	6, #7 and #8 )						[
İ	The finding includes:						İ
	the midning includes.	1				1	
Ì	1.Cross Refer to W12	20,2. During observation of					

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STATEMEN	T OF DEFICIENCIES	(Y4) DDO) (DED/0(IDB) (C) (1)	1			TOMP MO	<u>/. 0938-03</u>	<del>9</del> 1
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N		IPLE CONSTRUCTION	(X3) DATE S		
			- 1					
<u> </u>		09G002	B WII	NG _		02/6	09/2007	
NAMEOFF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1912001	_
NCC				6	200 2ND STREET, NW			
				V	VASHINGTON, DC 20011			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	·	PROVIDER'S PLAN OF CORRECT	LION	racet)	_
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD)	RE COOCC	(XS) COMPLETIO	N
		·		•	REFERENCED TO THE APPROPRIATE D	EFICIENCY)	DATE	
W 488	Continued From page	ge 53	W	 488			<del> </del>	_
		e day program on February		100				
	07, 2007, Client #7.	was provided with a plastic		ļ	1. Lunch is delivered in the classro	oom in		
	spoon to eat her 16	00 calorie low cholesterol diet.	.		disposable containers. Disposable u	tensils	21610=	
,	Dunng observation	of the dinner meal at the			are provided for all clients. A variet	yof	3/6/07	
	spoon to eat her me	s provided with a plastic eal. Interview with the facility			plastic utensils will be provided for 7 and all clients	client #		
	staff revealed that re	egular utensils are not						į
	provided or encoura	ged for the client to use at						ł
Ì	mealtimes. There w	as no evidence that the						ļ
	opportunity to learn	to utilize varied utensils for						
	eating was made av observations.	allable during the	}			1		- [
.		n of the dinner meal on						- [
*	February 6, 2007, C	fient # 1 was observed to eat				İ		-
}	his meal with a plast	ic fork. The client was						-
	observed to use his	fingers to push the food on			2. Metal utensil will be provided to	client#		
	Interview with the pu	ent from falling to the plate. tritionist on February 7, 2007	İ		7 and all clients during breakfast an	d	3/13/07	1
	revealed the client st	hould be provided metal			dinner.			1
	silverware with which	n to eat their meals. There						1
	was no evidence the	client was provided						1
	appropriate eating ut	ensils to eat his meals.						l
1	3. On the morning of	February 9, 2007 waffles,	i		7. O			1
	SVrup and sausage w	vere include on the breakfast			3. Staff was trained on family style on 3-14 07. Tening	lining		
	menu. Clients were c	bserved to not have the	1		on 3-14-07. Training will be on goin	g.	3/14/07	ı
	waffles cut to bite siz	e pieces but to bite directly						ı
	from the whole piece	s of waffles and sausage.				`		ı
	There was no eviden	ce that appropriate eating				1		ł
- 17	them or that the food	I to the clients able to use s were cut to bite size pieces						
	for the clients who ne	eded assistance.						
1.								
1.	4. The facility failed to	ensure clients were			4. Cross reference # 3			
	style dining.	nity to participate in family					3/14/07	
ā	a. At each observed r	neal time, (dinners and						
1	preakfasts) the food v	vas provided from the						

i	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB N	IO. 0938-039
	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER		IULTIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
ı			09G002	B WIN	NG <sub></sub>		
ı	NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STORET ADDOCAD AND		2/09/2007
I	NCC				STREET ADDRESS, CITY, STATE, ZI 6200 2ND STREET, NW	IP CODE	
I	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<del></del>	WASHINGTON, DC 20011		
	PREFIX TAG	LEACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		M PHOLIC AS AS AS AS	(X5) COMPLETION OATE
	r f f e to	observed to serve the observed to serve the plates for the clients that some of the clients that some of the clients their own plates with Further interview with hand over hand assist participate in the fand There was no evider an opportunity to participate in the fand the cook and the clients of the clients of the clients of the clients of their therapeutic devidence the clients was participate in family earning opportunity was reversed to serve the clients of their therapeutic devidence the clients was participate in family earning opportunity was reversed to serve the prescribe their therapeutic devidence the clients was participate in family earning opportunity was reversed to serve the serve to participate in family earning opportunity was reversed to serve the clients of the clients was reversed to serve the clients of the clients was reversed to serve the clients of the c	cial diets. Staff were cial diets. Staff were ne food from the bowls to the line food from the bowls to the line food from the bowls to the line food from the bowls to the line from staff. In staff indicated that with stance other client 's could nily style dining experience. Ince the clients were provided ticipate in family style dining.  O7, strafoam plates with lids trays of food brought from literal line from literal line from literal line food plates to ensure that they did type and portions of frond literal	W 4		will inquire ng utensils. special diets n Styrofoam	, exite
	h to in ca hi wi	was observed wearing is neck. The end of lacemat, as it extend to underneath the plate when the client move his wheelchair, the plate with the plate wheelchair, the plate is clothing, prior to staff indicated the ient from soiling his of	n February 7, 2007, Client # ng a long bib tied around the bib was used as a ed from the client 's neck e, which contained the food ed backward from the table blate moved with the client, spill the leftover food onto aff intervention. Interview bib is used to prevent the elothing. There was no evidence the client was		5.QMRP will retrain staff on protocol for client #5 by 3-20 Placemats will be provided b (See attachment sign in)	0-07.	3/20/07

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/28/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER-A BUILDING COMPLETED B, WING 09G002 02/09/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NCC 6200 2ND STREET, NW WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 488 Continued From page 55 W 488 provided with an appropriate placemat for use during his meal. 6. On February 7, 2007 during breakfast, Client # 6. QMRP ordered the arrest cup on 10 was offered his water from a spoon. Interview 3-12-07. cross reference W436 #4 with staff indicated the client has difficulty 3/12/07 consuming liquids. Further interview with staff and the review of the feeding protocol posted on the bulletin board and the clients record revealed the client should receive all liquids thickened to honey consistency except water. Record verification indicated a recommendation was made for Client #10 to have a special cup to improve his fluid intake on January 2007. At the time of the survey, there was no evidence the special cup had been provided for the client. 7. Cross refer to W484, b. The facility failed to ensure Client #10 was actively encouraged to 7. QMRP trained staff on client # 10 assist in feeding himself to the extent of his feeding protocol 3-7-07 capability and in accordance with his assessed cross reference W249 #3 need.

Health	Regulation Administra	ation				ORM APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER	(X2) MUI A. BUILO B. WING	ING	DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	09G002	DTDEET .			02/09/2007
	WO TIDEN ON SUFFLIER			DURESS, ÇIN D <b>STREET</b> ,	STATE, ZIP CODE	
NCC			WASHIN	GTON, DC	20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIATE DEFICIE	OSS- COMPLETE ENCY) DATE
1 000	INITIAL COMMENT	rs	<del></del>	1 000		
	2007. A random sa	was conducted on Fe impling of eight client oulation of twenty-ninus us disabilities.	s was			
	interviews with clien	ased on observations ts, family members, i y program staff, as w litation and administr cident reports.	facility rell as the		·	
1 041	3502.2(a) MEAL SE	RVICE / DINING AR	EAS	1041		
	Modified diets shall t	be as follows:				
	(a) Prescribed in the Habilitation Plan and prescription for the n the resident 's recon	the record of the nodified diet shall be	J		a. Client #6's diet order was placed in he IHP on 3/16/07	3/16/07
	This Statute is not me The finding includes:	net as evidenced by:			·	
	See Federal Deficien	cy Report - Citation \	W474.			
1 052	3502.10 MEAL SER\	/ICE / DINING AREA	ıs	1052		
	Each GHMRP shall e tables, chairs, eating designed to meet the each resident.	utensils, and dishes	i		Food services will provide appropriate utensils and condiments to clients. Cross reference W189 #8 pg 21	3/13/07
-	This Statute is not me The findings include:	et as evidenced by:				
i a	See Federal Deficienc and W488.	cy Report - Citations	W484			
ith Regulati	on Administration	<u> </u>				
	Ambus H. Harpe	x/ Virgil Muroh	1 KM	Prog	ram Mgr. HTLE 3-16-07	

Ambus H. Harper/ Virgi ( Muro ) & M-LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIED REPRESENTATIVE'S SIGNATURE

Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 09G002 NAME OF PROVIDER OR SUPPLIER 02/09/2007 STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW NCC WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(XS) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE F091 Continued From page 1 1091 1 091 3504.2 HOUSEKEEPING The facilities department will ensure that 1091 and equipment check and weather Housekeeping and maintenance equipment shall proofing occurs in fall prior to winter and be well constructed, properly maintained and in the spring. See W104 # 4 pg. 2 appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observation interview and record, the GHMRP facility failed to ensure the temperature in various areas of the building was maintained within a normal comfort zone. The findings include: See Federal Deficiency Report - Citation W429. 1 160 3507.1 POLICIES AND PROCEDURES 1160 Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure its written manual describing the policies and procedures it will follow was detailed and met the residents' needs. The finding includes: 1. The GHMRP failed to have a policy on HRC committee approved a policy for restricted access to the facility. On February 6, use of magnetic locks. Cross reference 2007 at 7:15 AM the main exit doors were W104 #3 on 3-15-07 observed to be locked. Interview with several direct care staff during the survey, indicated that

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING \_ 09G002 02/09/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW NCC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE 1160 Continued From page 2 1160 at times the door are not locked during the day. the doors were observed to remain locked throughout the survey. Interview with the Residential Program Manager ( RPM) revealed that the locks were installed to Cross reference W104 #3 prevent clients who have targeted behavior of abscondence from attempting to exit the facility. Additionally, the RPM indicated that this practice prevents unauthorized individuals from entering the building. There was no evidence the GHMRP had established a written policy on the use of locked doors. (See Federal Deficiency Report Citation W149) 1 228 3510.5(e) STAFF TRAINING 1228 Each training program shall include, but not be limited to, the following: (e) Resident 's rights: This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were Staff will be trained on clients Rights effectively trained in residents rights. Policy annually. The first Training is scheduled 4/4/07 The findings include: See Federal Deficiency Report - Citations W125, W137, W153, W154, and W247. 1 261 3512.2 RECORDKEEPING: GENERAL 1261 **PROVISIONS** Each record shall be kept in a centralized file and made available at all times for inspection and

lealth Regulation Administration

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STATEMEN AND PLAN	AT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM  09G002	RVCLIA MBER:	(X2) MUL A. BUILDI B. WING		(X3) DATE S COMPLI	
NAME OF F	PROVIDER OR SUPPLIER	V3G002	STREET ADD	DESC CITY	, STATE, ZIP CODE	02/0	9/2007
NCC			6200 2ND WASHING	STREET.	NW .		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	; =111.1	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	HOLED BE COORD	(X5) COMPLE DATE
	This Statute is not a Based on observation failed to ensure recoinspection at all time regulator agencies.  The finding includes  During the entrance	I of authorized regular met as evidenced by: on and interview the Cords were available fo es by personnel of aut	GHMRP r thorized	I-261	Residential Manager will en records are available to the s upon request	sure that	
	to be provided on Fe survey was made. In Program Manager (Findicated the team winformation on Febru	ebruary 7, 2007 during nterview with the Resign RPM) on February 8, 2 rould review the persolary 9, 2007. Interview 9, 2007 revealed the n was not available.	the idential 2007 printed w with e the	291	Olempa vi		
	signed by each indiving this Statute is not maked on interview and SHMRP failed to enspected was making the entry.	kept current, dated, a dual who makes an e et as evidenced by nd record review, the ure that each entry in signed by the individu	and ntry.		QMRP will ensure that all off documentation is signed and of documentation not signed will as a draft.	dated All	
1 355 3		cy Report - Citation W E / TRANSFER POL		355			

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PRINTED: 03/01/2007 FORM APPROVED

Healt	h Regulation Administr	ation				APPROVED
STATEN AND PL	IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-09G002	(X2) M A. BUII B. WIN		(X3) DATE S COMPLE	
NAME C	F PROVIDER OR SUPPLIER	<del></del>			02/0	9/2007
í		,		TY, STATE, ZIP CODE		
NCC		WAS	2ND STREET SHINGTON, DO	7, NW 5-20011		
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1 35	55 Continued From pa	ge 4	1 355			
	involuntary transfer	plan for voluntary or or discharge of a resident asis and shall provide the	on			
	the need to transfer	•	for	QMRP will ensure that writ for transfer are given to all a	tten notification appropriate	
	Based on interview :	met as evidenced by: and record review, the ovide evidence of a transfe	ः	Cross reference W159 #5	i	
	The finding includes	;				
٠	(See Federal Deficie	ency Report - Citation W20	)2)			j
1 37	3519.10 EMERGEN	CIES	1 379			
·	Health, Health Facilit unusual incident or e interferes with a resident arrangement, well be places the resident a be made by telephon	orting requirement in 3519 notify the Department of sies Division of any other vent which substantially dent's health, welfare, living or in any other way trisk. Such notification shall be motification within twenty-next work day.	ng all			
	This Statute is not me Based on interview ar GHMRP failed to ensi Health, Health Facilitie unusual incidents that a resident 's health.	nd record review the	th			

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STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB	CLIA BER:	(X2) MU A BUIL B. WIN		(X3) DATE S	
NAME OF	PROVIDER OR SUPPLIER	09G002				02/0	9/2007
	THO FIDER OR SUPPLIER				Y, STATE, ZIP CODE		
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1 379	Continued From pa	ge 5		1379		<del></del>	<del></del> -
	The finding includes	-	V153,		I 401-W120 An OT assessment was schedule client #7 (see attachment). For chad an assessment to see if she contains a see that the second seed of the contains a	lient # 6	
1 401	3520.3 PROFESSIONS	ON SERVICES: GENER	RAL	1401	her mouth. An informal reinforce her ability to wipe her mouth will continue.	ement of	
1 422	and evaluation, includevelopmental level services, and service deterioration or furth resident.  This Statute is not in Based on observation review, the GHMRP of professional service.  The findings include:  See Federal Deficient W159, W322, W331, W322, W331, W3521.3 HABILITATION Each GHMRP shall pand assistance to resident is Individent in the resident is not make a service of the GHMRP factor of the G	n, interview and record failed to ensure the proces.  TO Report Citations - V. W338 and W436.  TO AND TRAINING rovide habilitation, trainidents in accordance will be as evidenced by: In the interview and record ailed to ensure habilitation.	t ne Novision W120,	1 422	W159 2. Client #4 will receive adaptive improve his eating skills 4. Direct support staff will be retricted to the support staff will be retricted to the support staff will be retricted to the support staff will be developed in the support of the support staff will be developed in the support of the suppo	rained on oped for d in the //13/07 of reports.  his e of his AR ocare ger air is Nurses so on a	
s	The findings include: See Federal Deficienc V242, W249, and 252	y Report - Citations W	193,		staff was trained on the use of the co	ut.	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 8. WING 09G002 02/09/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6200 2ND STREET, NW NCC WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX -(EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE 1379 Continued From page 5 1379 The finding includes: An OT assessment was scheduled for 3-21-07 for client #7 upon assessment 3/21/07 client #6 demonstrated that she is able to See Federal Deficiency Report - Citation W153. wipe her mouth. See W159 3520.3 PROFESSION SERVICES: GENERAL 1401 **PROVISIONS** Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the provision of professional services. The findings include: See Federal Deficiency Report Citations - W120, I 422-W193 W159, W322, W331, W338 and W436. Staff was retrained on client #7 BSP. Staff was also trained on client #1 BSP 1 422 3521.3 HABILITATION AND TRAINING 1422 W242 Client #6 ability to wipe her mouth will be Each GHMRP shall provide habilitation, training monitored and reinforced in day program and assistance to residents in accordance with and at home. the resident's Individual Habilitation Plan. W249 Staff will be retrained on client #9 feeding This Statute is not met as evidenced by: protocol. Based on observation, interview and record 3. Staff will be retrained on client #10 review, the GHMRP failed to ensure habilitation feeding protocol. and training was provided. W252 Staff was retrained on implementing The findings include: feeding protocol. See Federal Deficiency Report - Citations W193. W242, W249, and 252.

Health Regulation Administration

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE	ER/CLIA		TIPLE CONSTRUCTION	(X3) DATE	
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1 500	3523.1 RESIDENT	'S RIGHTS		I 500			
	protected in accordance	dence director shall e sidents are observed ance with D.C. Law 2 applicable District and	and		Policy was drafted for use locks for ICF-MR and brown 3/15/07  W137	ught to the HRC	
	pased on interview :	met as evidenced by: and record review, th sure the protections	4 I V		Client #4 clothes was invertible perfect fitting. All ill-fitting removed  W149  Residential Program Managadministrators who review a incidents. The residential poprogram Manager will ensurincidents.	clothes will be sers are the all unusual epulation	
	See Federal Deficier W137, W149, W153	ncy Report - Citations , W154, W156, and N	W125, W264.		incidents are removed in a ti	mely manner	
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NAME OF PROVIDER OR SUPPLIER  N.C.C.  SUMMARY STATEMENT OF DEPICESHINGS.  PREFIX PAGE  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  R 000  INITIAL COMMENTS  A licensure survey was conducted from February 9, 2007. A random sample of eight clients was selected from a residential propulation of 29 individuals with varying degrees of mental retardation.  Personal records for staff were requested from the Residential Program Manager during the survey. Interview with the program manager on eight errivinal background checks were not available for review. The results of criminal background checks therefore continues to be pending.  STREET ADDRESS, CITY STATE, ZIP CODE  ### CODE 100	STATEMENT OF DEFICIE! AND PLAN OF CORRECT!	NCIES ION	(X1) PROVIDER/SUPPLII IDENTIFICATION NO 09G002	ER/CLIA IMBER:	(X2) MUL A BUILDI B WING		(X3) DATE S COMPLI	
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